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ABSTRACT

In an age of legal, clinical, and fiscal accountability, record keeping is an important component of professional counseling. The second edition of this book is intended to be used to: (1) explain the uses of a case record and who has access to it; (2) comprehend everyday problems associated with ineffective communication, including how records can be used against a person; (3) increase the awareness of legal trends; (4) demonstrate how records can be used to enhance the service relationship and promote consumer empowerment; and (5) help counselors face the challenges of accountability and ensure their ability to meet human needs. The overall goal of this publication is to help with risk management. The principles included are relevant to the job experience of all social service and health care professionals. Sections are included on the following topics: "Documentation: An Attorney's Perspective"; "A Comparison: Testifying in Court and Documenting in the Record"; "Documentation: An Auditor's Perspective"; "Electronic Records and Traditional Paper Records"; "Documentation: A Co-Worker's Perspective"; "Essential Elements in the Initial Assessment"; and "Documentation: A Client's Perspective." (Contains 20 references and lists 15 Web sites.) (JDM)

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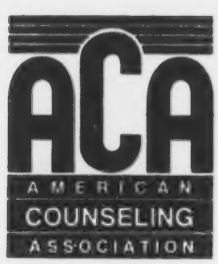
Documentation in Counseling Records

Second Edition

Robert Mitchell, ACSW

The ACA Legal Series

Series Editor:
Theodore P. Remley, Jr., JD, PhD



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Documentation in Counseling Records
Second Edition

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DEDICATION

This book is for every person who ever tried to help someone.
Each of you makes a difference.
You always have and you always will.

SPECIAL THANKS

To my parents, Isabel and William Mitchell, for teaching me that if something is worth doing, it is worth doing well.

To my wife, Carolyn, for love, patience, understanding, and support.

To my children, Debbie and Rob, for their love and encouragement.

To Rita Gray Recktenwald, for friendly, but firm editing for both the first and second editions of *Documentation in Counseling Records*.

To the American Counseling Association for generous support, encouragement, and the privilege of preparing a second edition of this publication in the Legal Series.

—Robert W. Mitchell, ACSW

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ABOUT THE AUTHOR

Robert W. Mitchell, ACSW, began his career as a children's protective service worker in 1959. Working on behalf of abused and neglected children, he made frequent court appearances and quickly learned the importance of good documentation. He obtained a master's degree from the University of Louisville Raymond Kent School of Social Work in 1962.

In 1973, he was employed as a social worker by one of the largest mental health agencies in the nation. The organization was audited in 1978 and went bankrupt, in part because of its inadequate record keeping. It was a difficult but effective way to learn more about the importance of documentation. Over the next 3 years he developed a training program designed to help counselors document professional judgments and interventions. His program, "What Every Clinician Should Know About Money," was published in 1981 (in H. Fishman, Ed., *Creativity and Innovation: Challenge of the 80s,* pp. 117–126, Davis, CA: Pyramid).

He has been a member of the National Association of Social Workers (NASW) since 1962 and the Academy of Certified Social Workers since 1965. Mr. Mitchell was named Social Worker of the Year in 1988 by the Kentucky chapter of the NASW. Later that year he received the Distinguished Citizen Award from the mayor of Louisville and the Honorable Order of the Kentucky Colonels from the governor.

In 1990, the NASW Malpractice Insurance Trust released *The Client Record and Professional Accountability,* an educational audiovisual tape based, in part, on Mr. Mitchell's documentation and risk management workshop. The tape contains segments of his program and refers to him as an expert.

Mr. Mitchell is a founding member of the American Association for Therapeutic Humor. Music has always been an extension of his social work values, and he has been proclaimed the Kentucky Chapter Bard by the executive committee of the state chapter of the NASW. His first recording, "I Need a Respite," was released in 1992. "Some Days This Place Is a Zoo" was released in 1994. The 1995 *Encyclopedia of Social Work* (19th ed., NASW Press) contains an article noting that Mr. Mitchell is one of a small number of professionals who commercially record music for a specific social-work-related purpose. According to the article, his "music evokes laughter and self-therapy for dealing with burnout." Several of his songs are included in this monograph.

Since 1979 he has been with Seven Counties Services, Inc., a mental health/developmental disability/substance abuse agency in Louisville, Kentucky. He was the first manager of accounts receivable for this $54 million organization. Later, Mr. Mitchell transferred to program planning and evaluation and, still later, was promoted to internal compliance auditor, his current job title.

He is a former member of the National Speakers Association and the Institute for Internal Auditors. Mr. Mitchell has provided training to over 150,000 professionals in 41 states and Canada. A partial listing of audiences includes the International Association of Psycho-Social Rehabilitation Services, Canadian Mental Health Association, Child Welfare League of America, Mayo Clinic, National Rehabilitation Association, U.S. Public Health Service, Mental Health in Corrections Symposium, Association of Behavioral Healthcare Management, American Association of Homes and Services for the Aging, Alcohol and Drug Rehabilitation Wellness Institute, National Council for Community Mental Health Centers, and Developmental Disabilities Symposium.

PREFACE

In 1990, Theodore P. Remley, Jr., JD, PhD, and editor of the American Counseling Association's Legal Series, attended my documentation workshop and was instrumental in having it published as Volume 2 in the Legal Series. This second edition is designed to expand on information in the first edition and cover some issues that were not discussed in the previous volume.

In an age of legal, clinical, and fiscal accountability, record keeping is an important component of professional counseling. As counselors enter the 21st century, we must accept reality, and the reality is this:

- Lawsuits against counselors continue to increase. Without adequate documentation, the counselor's vulnerability is also increased.
- Counselors and client records will continue to be ordered into court rooms because the legal system believes the records contain information needed to make decisions about child custody, involuntary hospitalization, and a wide array of other situations. Missing, incomplete, and inadequate charts may be harmful to the client as well as the counselor.
- There will be occasions when the primary counselor is sick, on vacation, or otherwise unavailable to provide emergency service. Someone else will depend on the chart to make clinical decisions. Adequate records can insure appropriate intervention and continuity of care.
- All funding sources are demanding documentation that verifies the need for and the rendering of reimbursable activity.

- Utilization review, peer review, and quality assurance reviews will continue to be important parts of professional counseling. A record is the primary source document.

This volume has a number of key purposes:

- to understand the uses of a record and those who have access to it;
- to comprehend everyday problems associated with ineffective communication, including how records can be used against you;
- to increase awareness of legal trends, the changing definition of confidentiality, and the most frequent causes for a malpractice suit;
- to demonstrate how records can be used to enhance the service relationship and promote consumer empowerment; and
- to identify the record as a resource that can help counselors face the challenges of accountability and ensure the ability to meet human needs.

This second edition, like the first, does not provide a failsafe solution to all record-keeping problems. Certainly, it is not a substitute for competent legal advice.

Printed materials, titled and untitled, aided in the development of my workshop and this monograph. Although it is impossible to credit each source of information, this edition contains a list of references and suggested reading materials, some of which influenced the development of this work. When actual examples of clinical documentation are used, names and dates have been changed to protect confidentiality.

You may not agree with everything in this monograph, and some material may not be applicable to your work. It is also important to understand that this monograph is about risk management, not risk elimination. Nevertheless, the principles are relevant to all social service and health care professionals including those in mental health, developmental disability, substance abuse, schools, managed care, criminal justice, psychosocial rehabilitation, and case management, and in both private or public practice. Experienced staff will find this monograph a useful refresher course, and new staff will obtain a sound foundation upon which to base documentation.

This monograph cannot be as comprehensive or as much fun as a live workshop for several reasons. We are not in a room filled with people, and there is no opportunity for discussion. I cannot show my audiovisual tape titled *No Good Deed Will Go Unpunished*. In addition, I always have my guitar and sing a few humorous songs. Today, we cannot sing together. Nevertheless, I hope to help you learn to write with pride as you document professional interventions and judgments.

GLOSSARY

Client: The recipient of any professional intervention from a counselor. Also referred to as consumer, patient, member, resident, or beneficiary. A client has also signed a form granting the counselor permission to provide service, or in the case of a child or person who has been declared incompetent, signed permission has been obtained from the parent/guardian, or the counselor has received a copy of a court order that provides a service directive.

Confidentiality: In general terms, the maintenance of client secrets, but the concept goes beyond the record and covers communication between counselor and patient. The purpose of confidentiality is to encourage candor so that the client yields more thorough information, thereby promoting better diagnosis and treatment.

Counselor: The service provider. This term includes all professionals, such as social workers, nurses, psychologists, psychiatrists, case managers, and therapists.

Plan: A document that details why the client is being served, what is going to be done, and lists measurable and desired outcomes. This is sometimes referred to as treatment plan, individual habilitation plan, plan of care, service plan, residential plan, individual education plan, rehabilitation or vocational plan, and case management plan.

Privileged communication: A state statute that must specifically identify the communication between a category of professionals and their clients as privileged and not subject to disclosure. Privilege, like confidentiality in general, exists for the benefit of the client and can be waived by the client. There are many exceptions to general rules of law and ethics. When a judge orders a

counselor to answer questions or to provide copies of the counseling record, the orders are absolute unless they are reversed by a higher court or suspended while an appeal is being considered by a higher court. As a result, counselors who comply with a judge's orders generally cannot be held liable even if someone's legal rights are violated in the process. Counselors who plan to refuse to comply must have their own attorney and must rely on legal advice. Counselors have an ethical responsibility to protest an order issued by a judge if they believe the order violates an ethical obligation. However, if a judge rules the order will stand, a counselor must comply, or may be held in contempt of court.

Record: The organized file (paper or electronic) containing clinical, fiscal, demographic, and other information as deemed necessary for effective service delivery. It includes any information used for the purpose of diagnosis and/or treatment. The record is maintained in accordance with state standards, organizational procedure manuals, and funding source regulations. It is also referred to as a chart or folder and may include any other written documents, audio or video recordings, or other tangible items that contain client information.

Service: A generic term referring to a professional intervention. This term includes, but is not limited to, counseling, evaluation, consultation, individual therapy, family therapy, group therapy, art therapy, psychosocial rehabilitation, chemotherapy, behavior modification, case management, and home visits.

Staff note: A counselor's entry that documents professional judgment or intervention. This is sometimes referred to as clinical entry, service note, progress note, daily note, group note, weekly summary, or service log.

Subpoena: A legal document issued under the auspices of a court designed to compel a person to appear in court and give testimony. It may also require that the counselor bring records to court.

Subpoena duces tecum: The legal document issued under the auspices of a court that requires submission of specific records as described in the subpoena.

Documentation: An Attorney's Perspective

My professional career began 40 years ago as a child protective service caseworker, so I was in a juvenile courtroom working with attorneys my first week on the job. It did not take long for me to discover how inadequate documentation can be effectively used against a counselor and his or her agency. In the years since that first week, I have learned a great deal about an attorney's perspective on the issues that are discussed throughout this monograph. An awareness of the fine points of that perspective is an invaluable asset for any counseling professional.

In a courtroom, your counseling records can be manipulated in ways you cannot imagine. Remember, each attorney has an obligation to advocate his or her client's interest to the best of the attorney's ability. In the event of a malpractice suit, someone told his or her lawyer that you are so incompetent and your programs are so ineffective that you should be sued. Some of the reasons a counselor

is called into court include, but are not limited to, breach of confidentiality, incorrect treatment, improper placement, sexual involvement, failure to provide a safe environment, failure to be available when needed, a client's suicide or attempted suicide, abandonment, and negligence in hiring and supervising staff.

Staff Credentials

If you are in a position to hire staff, and they say they are a certified counselor, registered nurse, certified psychologist, licensed social worker, or whatever, you cannot take their word for it. You must obtain a copy of their current license or certification. Many times individuals fail to renew their certifications, and some do not complete their studies. Obtain a copy of a valid transcript or diploma and place it in the individual's human resources file. You must also check references, former employers, and perhaps consider a criminal background check. It is also important to keep copies of this information in the individual's personnel file.

Client charts and staff personnel files are of use to a plaintiff's attorney only in so far as they help establish a reasonable doubt about your qualifications and the quality of your interventions. Even if a claim against you is invalid, you must defend yourself, and inadequate documentation could result in damage to your professional reputation.

Missing Entries

One of the most frequent problems I have observed is missing entries. You can complain about paperwork, but if you have no documentation, you have no defense. A lawyer once told me in jest that one of the first things he was taught in law school was, "In God we trust; all others must document."

Another common problem in the counseling record relates to missing, incomplete, or altered dates. Be sure each entry lists month, day, and year. Do not leave anything out, or you create doubt.

Incomplete Forms

Blank spaces and incomplete forms provide a lawyer with an opportunity to walk over to the jury, show them your half-completed work, and say you could not obtain information, or you did not care enough to obtain the information. These statements may not be true, but the fact that the form is not completed provides an attorney with an opportunity to generate doubt about a counselor's ability. Maybe the information did not apply, but how are other readers supposed to know that if you do not tell them? When something does not apply, write "not applicable" in the space.

Credentials and Signatures

Sign each entry with your name, not initials. Then list your credentials, such as certified counselor, licensed social worker, registered nurse. Many staff sign their name and list a job title, but that is not as effective as listing credentials because not every one understands or agrees about the difference between a Counselor I and a Counselor IV or a Therapist I and a Senior Therapist. As we enter the age of electronic records, a signature is still important. You need a system insuring that the signature on the screen confirms the entry was made by the particular individual and that the note has not been altered.

Altered Documentation

Did you know that one of a lawyer's best friends is a bottle of white out? I have read many altered documents. If you make a mistake, the most universally acceptable method to make a correction is to take a pen and draw a line through the entry. But never obliterate words; they must remain legible. Above the line write the word *error*. Then, hopefully on the same page, write the words *corrected entry* and enter the correct information. If you discover an error several weeks after the entry has been made, draw a line through the entry (never obliterate words; they must be legible). Above the line write the word *error*, enter the date of the change, and initial it. Then, hope-

fully on the same page, write the words *corrected entry*, enter the correct information, and cross-reference it with the original note.

If you delete one or two words from a sentence, the meaning of a sentence can be changed; and yet I have read records with five or six lines deleted. That sort of thing allows an attorney to walk over to the jury, show them your altered document, and say, "I wonder what the provider is trying to hide." Maybe nothing, but you altered a document, didn't you?

With a court order, a lawyer can get a great deal of your chart, maybe not everything, but enough to help establish doubt and, maybe, guilt. Is the record going to help you or a lawyer who is looking for inadequate, vague, conflicting, or altered information? There are more lawyers than ever before, so it is not surprising that there are expanding theories of liability.

As a professional counselor, you will constantly deal with four conflicting principles:

1. the client's right to privacy versus the counselor's obligation to protect society;
2. the client's right of confidentiality versus the counselor's responsibility to protect the community from violent behavior;
3. the client's right to receive service in the least restrictive setting versus the counselor's obligation to provide close supervision, continuous monitoring, and a safe environment; and
4. the client's right to die versus the counselor's obligation to save lives.

When a client is suicidal, you may wish to involve the family because if there is a suicide, surviving family members can sue you. An attorney will attempt to show that the counselor did not properly supervise the client, did not provide a safe environment, or was not qualified.

The mere fact that you exercised what you considered good judgment will not protect you. Someone once told me, "The truth is irrelevant; it is the evidence that counts." One counselor's attorney said, "I would rather have a good chart than anything else."

There are seven ways to guarantee a lawsuit:

1. Document that something needs to be done; then do not do it.
2. Do not keep records current.
3. Do not obtain complete assessments or develop a comprehensive treatment plan.
4. Establish policies and procedures, but do not follow them.
5. Do not review or audit your records.
6. Nurture a dependent relationship and then cut it off quickly.
7. Combine a suicidal client with a provider who has a reputation for sexual impropriety.

Testifying

In all honesty, the likelihood of your being taken to court for malpractice is unlikely, but it is highly likely that you and/or your records may be brought into court and that you will be a witness in custody disputes, placement decisions, and a wide array of other situations.

Although several sections of this monograph deal primarily with malpractice issues, the same concepts apply to cases in which a counselor is required to testify as a witness, not a defendant. If you are not prepared for the unexpected, are you going to be prepared for the consequences?

When you are in a court of law (for whatever reason), you have an obligation to tell the truth, the whole truth, and nothing but the truth. When you are in your office writing, you have the same obligation. Write the truth, the whole truth, and nothing but the truth.

A Comparison: Testifying in Court and Documenting in the Record

Although lawsuits against counselors have been increasing each year, statistics indicate that most counselors will not be sued. Nevertheless, there is a high likelihood that you and/or your records will, at some time, be in a courtroom. The legal system believes you and/or the chart may have information needed to make an informed decision in a child custody dispute, an involuntary hospitalization, and a wide array of other situations. Here are some suggestions that may be useful in the event you are ordered to appear or submit a record.

- **In court:** Tell the truth. A lie can lose the case, no matter how small or unimportant the falsehood may seem. Be sure to discuss the case truthfully with your attorney before you get on the stand.
  In charting: Write the truth. Words must be an accurate reflection of the situation, precise and current. Horace Mann said, "You need not tell all the truth, unless to those who have a right to know. But let all you tell be the truth."

- **In court:** Do not guess. If you do not know or cannot remember, say so. **In charting:** Do not make assumptions. If you suspect something, your opinion must be substantiated. If you do not know something or cannot remember, do not write it.
- **In court:** Be sure you understand the question before you answer. When in doubt, ask the attorney to explain or to use language you understand. You cannot provide a truthful or accurate answer unless you understand the question. **In charting:** Understand the purpose of the counseling record. If a judgment or intervention is not documented, it was not rendered. Effective communication requires a mutually understandable vocabulary. Write in words that you or another will understand.
- **In court:** Take your time. Be certain that you are answering the question being asked; then respond. If the question is complicated, wait for your attorney to offer an objection. Then wait for the judge to make a ruling. You may not have to answer every question. **In charting:** Take your time. Be certain you understand the importance of the charting. Include information that is logical and relates to the plan of care. Do not rush; you may inadvertently neglect to include clinically relevant data.
- **In court:** Answer only the question that is asked and stop. An attorney will ask for additional information when it is needed. You could inadvertently provide too much information and break a confidence. **In charting:** Enter only information that is pertinent to the client's situation and stop. The counseling record should be a logical, short story. It begins with an assessment and moves to a plan, staff notes, case reviews, and a termination. Generally speaking, if an entry does not relate to the problems listed in the most recent plan or review, it is not necessary. (For exceptions, see the chapter High-Risk Cases.)

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I am reminded of a story of the small child who came home and asked the parents, "Where did I come from?" The nervous parents then went into a detailed explanation of where babies come from. "No, No!" the horrified child shouted when the

explanation was through. "Jimmy comes from Kentucky! Where do I come from?" In short, answer the question asked and nothing more.

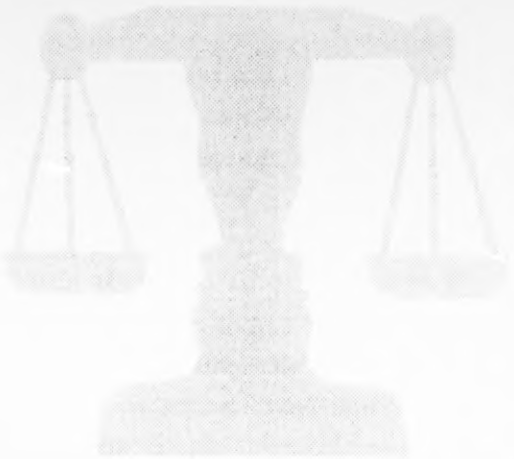
⚖

- **In court:** Talk loudly enough to be heard. Sit erect, do not chew gum, and keep your hands away from your mouth. **In charting:** Write legibly and organize your thoughts before you write them. Eliminate unfounded opinions and maintain a current record.
- **In court:** Enunciate; give clear answers so the court reporter can record accurate exchanges. An answer is not a nod of the head or a shrug of the shoulders. **In charting:** Use easily understood words; define the terms because professional jargon may not always mean the same thing to everyone; eliminate qualifiers as often as possible.
- **In court:** Be aware of questions involving time. When you are making an estimate or expressing an opinion, let the court know it is your estimate or opinion. **In charting:** Be specific about dates (include month, day, and year). When you are making an estimate or expressing an opinion, label the entry *clinical opinion* or *diagnostic impression*.
- **In court:** Be calm. There is often a tendency to become hostile or defensive. Anger and hostility will distract the judge and jury from what you have to say. **In charting:** Be calm. When you become frustrated with a client, office situation, or a family member, an entry can reflect those negative feelings and distract from the clinical information. A staff note can say more about the writer than the client. I am reminded of a note that said, "John was more cooperative than expected." Another note said, "Jane's next appointment is August 22nd. I'll bet she does not keep it." That kind of entry tells a reader something about the writer but not much about the patient.
- **In court:** Be courteous. Say, "Yes sir/madam" or "No sir/madam." Address the judge as "Your Honor." **In charting:** Be courteous. Words can be mean spirited. I have actually found the following words in client charts: obnoxious, fat, stupid, lazy, and

stubborn. Define adjectives; use words that specifically describe behaviors. Involve the client as often as possible in the documentation process. It is courteous and can be an effective part of the treatment process. It also promotes empowerment.

- **In court:** Looks are important. How you testify is as important as what you have to say. **In charting:** Looks are also important. Records must reflect the professional you are. Charts must be current, logical, legible, neat, and organized. Blank spaces, out-of-sequence notes, sloppiness, and altered information will have a negative impact on credibility.
- **In court:** Give a definite answer when you can. There is a tendency to hesitate in response to a question such as, "Are you absolutely sure?" If you are certain, be firm, and do not be afraid to say so. **In charting:** Write with pride and professional authority. Remember, too, that usefulness requires specificity, and vague writing could be interpreted as incompetence. Records should not be filled with a preponderance of qualifiers such as *seems*, *appears*, and *possibly*. Use these words sparingly.
- **In court:** Trial preparation is proper and necessary. **In charting:** think before you write. It is often difficult or impossible to take back what you have documented. Do not forget that others may need the chart when you are not available, so write in a style that will be understood by you or a co-worker.

Reportedly, many people had difficulty understanding the work of poet, Robert Browning. Playwright Rudolf Besier, in his play *The Barretts of Wimpole Street*, recounts an incident with Browning's ardent admirer and soon-to-be wife, poet Elizabeth Barrett. She is said to have asked him to explain one of his poems, and after he re-read it he said, "When I wrote that, God and I knew what it meant. Today, only God knows." If you or I read your notes 6 weeks from now, will we know what you meant?



Documentation: An Auditor's Perspective

Some counselors rely on third-party funding for a portion of their operating revenue. It might be a special grant, designated state funding, Medicaid, Medicare, or any other insurance company. When you accept funding, you must also accept the payer's regulations. Auditors who monitor health care and social service organizations read counseling records to determine the validity of billings. When documentation is missing or considered insufficient, a payback will be requested and future funding may be placed in jeopardy.

The first thing an auditor looks for is a *plan of care*. It may be called a treatment plan, habilitation plan, family plan, service plan, or whatever. Simply put, the auditor will look for a document that verifies the need for the service. If there is no need, the payer has no obligation to pay you.

The second thing an auditor looks for are *notes* or *logs*. The substance of counseling entries must verify a legally reimbursable service

as the funding source defines it. If you are not sure what to write, get a copy of the payer's service definitions and read them. After you read them, use some of the payer's words because the payer may not understand some of your professional terminology. More importantly, if you are not providing services as the funding source defines them, stop billing the funding source.

Not only do payers have specific definitions for a payable service but also specific regulations regarding educational qualifications for anyone who bills them. Additionally, some interventions are never payable, so it is important to contact the third-party payer before billing starts. It is the counselor's responsibility to verify with the payer which providers and methodologies are reimbursable.

Managed care companies require plans and notes to justify medical or psychiatric necessity. Most importantly, a counselor must acknowledge the fact that the managed care company makes all final decisions about what is reasonable and necessary. The content of your record must demonstrate benefits and outcome measures. One company (name deleted) brochure contains the following statement: "To avoid patient malingering, two audits per year will be conducted."

Counselors frequently ask me for the magic words that will insure satisfactory records. Unfortunately, there is no set of words that assures acceptance from every auditor. Nevertheless, common sense and good practice can be useful in a resolution of this concern. Here are some guidelines.

What Not to Do

Do not write a plan that ignores the problems listed in the assessment. Do not write a review that ignores the problems listed in the most recent notes.

Group names may not indicate reimbursable or professional therapy. Therefore, do not use group titles such as Listen and Learn, Life's No Picnic, Video Group, Personality Plus, or Over-the-Hill Gang, which are actual titles that have appeared in records I have read. Although these titles may be appealing to members of a group, they will appear flippant and imprecise to an auditor.

Group notes frequently focus on an activity rather than a professional intervention. Avoid such terminology as the following unless you can document how the activity was used to facilitate a therapeutic service:

- playing cards;
- making cookies;
- celebrating a birthday;
- making holiday decorations; and
- listening to music.

Group and individual notes must be more than an observation or opinion. The full texts of two inadequate entries are as follows: (a) "Agitated, interaction was rather flighty. Grooming & hygiene was [sic] fair. Remission marginal," and (b) "Client in as scheduled. Was appropriate although she did seem to constantly chatter without allowing time for interaction from others. Needs some effort to involve her with others. Remission adequate." Some concrete suggestions for improvement are included later in this chapter.

Do not use a *master note* that always contains the same information day after day, week after week, month after month. Sometimes, much of the preprinted form is left blank. Do not leave blank spaces.

Some notes indicate "all members benefitted" or "client enjoyed self," but there is no indication of the counseling service or the therapeutic benefit.

Notes are often brief and vague. Therefore, it is difficult to determine the specific type of service. Too often, notes do not explain how the session related to the problems/goals listed in the plan or most recent review.

What You Must Do

A record must be a legible, current, and accurate description of rendered services.

After the assessment has been obtained, you must develop a plan of care. The components of a plan will include but are not limited to five items.

1. **Problem statement:** What are the specific problems? An unclear example is "anxiety." To make it clear, write something like "anxiety related to possible loss of job."
2. **Goal statement and expected date of goal achievement:** What specifics will result from counseling? Set specific and measurable goals that relate to the specific problems listed in the assessment. If you can SEE a specific behavior related to the problem, or if you HEAR the client say something related to the problem, then the goal is probably "acceptable." If you write a goal, such as "Become responsible and maintain remission," ask the client to repeat it like this, "Watch me become responsible and maintain remission." Then, write "Take medications as prescribed" or "Remain in community for 6 months without readmission to hospital."
3. **Treatment modality:** Information in the assessment must confirm a need for the kind of service listed in this section of the plan. An unclear example of the service to be provided is "nonthreatening support." A clear example might be "weekly group therapy for depressed men." To be a billable service, the intervention must be provided by a covered professional who is considered qualified by the funding source. A counselor must ask himself or herself, "Am I authorized and qualified to provide the treatment(s) listed in a plan of care?" If the answer is "no," a counselor should arrange for the client to be seen by someone who is qualified.
4. **Clinical impression or diagnosis:** It must be an accurate reflection of the patient's mental health as indicated in the plan and in the assessment. Spell out the full diagnostic terms and list the complete DSM or ICD codes. Some diagnostic codes are not reimbursable. Do not overstate a client's condition to make it appear as though the individual has a billable diagnosis. To do so is illegal and unethical.

5. **Names and credentials:** Names and credentials of each person who participated in the development of the plan as well as the name of the assigned therapist must be listed. The person who wrote the plan or review must sign and date it. In many cases, the medical doctor must also sign. Any individual who did not actually participate in the formulation of a plan should not sign or have his or her name listed.

With regard to a plan of care, The *ACA Code of Ethics and Standards of Practice* (1995) had this to say: "Counselors and their clients work jointly in devising integrated, individual counseling plans that offer reasonable promise of success and are consistent with abilities and circumstances of clients. Counselors and clients regularly review plans to ensure their continued viability and effectiveness, respecting clients' freedom of choice" (A.1.).

Three Essential Elements for Staff Notes

Once a plan of care has been clearly established, staff notes document that the specific services listed in the plan have been provided. The notes, of course, must also be precise and should contain the following essential elements:

1. **Confirmation of a service:** Verbs are important. What did you do? What did the patient do? Use action words such as *focused, stabilized, recommended, discussed, assisted, identified, referred, medicated, evaluated,* or *interpreted*.

2. **Verification of the information implied within a billing code:** Will the content of a staff note confirm (a) the same date as the billed date? (b) the same number of billed minutes (units of service)? (c) the same kind of professional? and (d) the same type of service? If a billing code indicates a 45-minute individual therapy session was provided on 4/11/2002 by a certified counselor, can you imagine the fiscal implications of a note dated 4/13/2002, titled "group therapy for 30 minutes," signed by a case manager? As an auditor, I have seen such discrepancies.

3. **An original legible signature, not a rubber stamp or initials:** Some notes must also be co-signed. The only way to know about each entry is to read and comply with your state's licensure and funding source regulations.

Good staff notes connect interventions to the plan. Nouns are important! What issues received your professional intervention? Use words such as *aggression, anxiety, depression, hostility, isolation, medication, hypochondria, dependence, depersonalization*, or *rationalization*. A counselor must read the payer service definitions because some terms used in a staff note, such as *education, socialization, encouragement, religion, art*, and *music*, may not confirm a reimbursable service.

Each person is capable of a multitude of mannerisms for any given characteristic. When you use words such as *abusive, argumentative*, or *dangerous*, you must define them or list the specific behavior or client statement. Other words that cause confusion are *demanding, disturbed, resistive, spontaneous, regressed, evasive, indifferent, unresponsive, disruptive, compulsive, extensive, impaired*, or *psychotic*. If these are the issues you deal with, write about them. But explain them in the context of the service provided.

Other Issues

Never bill for a service you did not provide. Never embellish or lie in a note for the purpose of making it appear that a billable service was rendered. The note must be an accurate reflection of the service you provided. You are a professional, and as such, your actions must be legal, moral, and ethical. Any deviation is unacceptable. As stated in the *ACA Code of Ethics and Standards of Practice* (1995), "Counselors are accurate, honest, and unbiased in reporting their professional activities and judgments to appropriate third parties including courts, health insurance companies . . . and others" (C.5.c.).

Electronic Records and Traditional Paper Records

In the fall of 1999, the U.S. Department of Health and Human Services issued its proposed *Standards for Privacy of Individually Identifiable Health Information* for governing electronically stored or transmitted records. Since that time there has been an ongoing controversy about the nature of these proposed regulations. Professional counselors are rightly concerned that the regulations would eliminate the requirement for clients' written authorization for release of information, which would violate the profession's Code of Ethics. Final legislation about this issue is due to take effect in April 2002.

This monograph cannot resolve the myriad confidentiality concerns generated by an electronic record or by these proposed regulations. Our topic is substantive documentation, not data protection.

Confidentiality issues are legitimate concerns, however, because new age technology has compromised the privacy of each individual you serve. As organizations increase dependence on nonpaper

records, the risk for improper access and disclosure increases. There is also the danger that a virus can intentionally or inadvertently alter and/or negate the integrity of electronic data.

Information is no longer kept only on pieces of paper in a secured room. It is stored and distributed through e-mail, voice mail, fax machines, dictation, computers, and computerized printouts. Electronically stored information is accessible by countless numbers of people. The most comprehensive security system can fail when unethical or disgruntled employees and external hackers obtain information.

The patchwork of state and federal laws does not provide 100% protection to anyone. Unfortunately, you can be sure that someone who has no right to information can obtain it and misuse it. Nevertheless, computerized information is here to stay.

Each day the PC (personal computer) is becoming a more popular technology for storage and transmission of vast amounts of information. More than one book is required to address all the security and reliability aspects of electronic record keeping. Nevertheless, it is appropriate and necessary to make some suggestions within this legal series. I cannot and will not presume to advise you as to which operating system is best suited to your needs. However, it is reasonable to keep the following points in mind.

There must be a security component that insures the protection of confidential information. Not everyone has a need or right to know what is contained in a client's file, so care must be taken to establish, document, and adhere to a clear-cut access procedure. Levels of priority to access client information must be established, and clearance to access data must be authorized in accordance with job title/responsibilities. A priority level should also determine who can enter new data, edit existing data, delete data, or "view only." When one staff person can edit or delete the information entered by another individual, the integrity of the data is compromised, and staff relations can become strained because one person believes information is clinically significant but another does not. You may even decide to maintain a paper record/log that verifies any modification of the information after it was originally entered in the electronic record. Perhaps a supervisor should be required to sign a form authorizing any change(s).

Your system should not only have password protection but also the ability to know who is logged on, who was logged on, who was denied access, dates and time of user activity, what data were printed by each user, and what work stations were involved. Each user should be provided with one code to log on an information system and another code/password actually to access confidential client data. You may want to provide an employee with a *floating ID and password*, that is, words that permit a user to access data from more than one work station.

Electronic records will allow you and others to share enormous amounts of sensitive information quickly. Again, you must have a policy and procedure that makes every attempt to insure confidentiality. Be careful what you share because as soon as your data enter another system and become subject to different readers' interpretations, you may lose control of the intended meaning of the information. You do not know who will use it, how it will be used, if they will interpret it the way you wanted, if it will be modified, or with whom it may be shared.

The record will contain information about an individual and should be, therefore, an accurate reflection of the client, not a canned or prepackaged program that is so vague that entries could have been written about anyone who ever sought health care or human services. A system must permit staff to edit or add to suggested sentences in a prepackaged plan, review, assessment, staff note, or any other clinical entry. Many organizations have developed formats that meet specific needs and reflect client differences, goals, problem areas. The system you choose should permit you to use and, perhaps, strengthen existing forms. Systems that are text limited not only deny the counselor an opportunity to enter more than one or two lines of information but also generate staff frustration because there is no room to enter data that are considered clinically significant.

If you are going to rely on electronic records, it is imperative to provide training and supervision. When staff with poor typing skills are responsible for data entry, reliability and usefulness are adversely affected, thereby increasing your risk exposure.

Information from a variety of fields/screens must be consistent to insure confidence. Contradictory information can indicate staff

incompetence and/or no data integrity. When section A lists one diagnosis and section B lists a different diagnosis, what is a reader to believe and act on? If one field says the client is single but another field says the client is married, a reader/user is confused. When screen F indicates the client is living with relatives while screen G indicates the client is living alone in an apartment, confusion results and the quality of care is compromised.

All systems crash now and then, so use disks, on a regularly scheduled basis, to back up counseling data.

To insure accuracy, consider the use of a program that automatically includes date of data entry as well as the authorized signature of the service provider.

In an age of ever-increasing information technology, counselors must exercise caution when selecting data for inclusion in the record. As other sections of this monograph point out, too much information equates to breach of confidentiality. I used to joke about getting a hernia from trying to lift a three-volume, 30-pound chart. Although a disk will not weigh 30 pounds, it is possible to enter so much information that it becomes incomprehensible.

Regardless of whether you use paper or an electronic medium, the following points remain valid:

- Service providers need timely, accurate, and comprehensive information. Lack of information can impede quality of care because the decision-making process is placed at risk.
- An organization must comply with its own written policy related to record keeping and confidentiality. In the event of litigation, "failure to comply" can be used against the service provider.
- One way to avoid misuse of information is to have trained employees who are committed to protecting the privacy of each consumer.

Whether you write on a piece of paper or make an entry into an electronic record, you must make seven assumptions:

1. This record is going to be subpoenaed and the court must understand what went on. I may or may not be with the agency when it happens.

2. Someone else will have to read and understand what I write when I am sick or on vacation or there is an emergency.
3. Legislation that opens a record to the client exists now or will be passed.
4. I cannot be as accurate if I wait days or weeks to write a note, so I'll do it today.
5. This note will be the best possible reflection of my professional abilities.
6. No contact is considered a service until my entry is in the record.
7. This entry will be selected by the division of audits to verify a legally reimbursable service as defined by the funding source.

Use of electronic record-keeping systems may not always enable the counselor to save time or spend more time providing services. But such systems can eliminate errors caused by such things as illegible handwriting. As this monograph was being prepared, a Texas court was considering a case involving a doctor's and a pharmacist's liability. The pharmacist was unable to read the doctor's handwriting and provided medication that resulted in the patient's death. A jury found the doctor, the pharmacist, and the pharmacy guilty of medical negligence and awarded $450,000 actual damages. ("Teresa Vasquez," 1999.)

A personal example makes the same point but with less catastrophic results. Recently a hospital lab technician could not read the doctor's order for my blood work. So I waited an hour for some responsible person to decipher it. The doctor was out, but one of his nurses was eventually able to translate his writing. No real harm done, but the potential was there.

Poor handwriting is also unconscionable and potentially deadly in the counseling profession. Some clinical entries appear to be a misplaced Rorschach. Illegible entries may possibly endanger the lives of clients and others in the community. There are no known national statistics to confirm that patients are being harmed, but 40 years of experience and recent news coverage indicate the problem is all too common.

These kinds of mistakes are what high-quality electronic record keeping can help professionals avoid. For counseling professionals to take advantage of this technology, we must obtain excellent and ongoing training in appropriate and discipline-specific software. Electronic records responsibly used and monitored will best serve both the counselor and the client of the future.

Documentation: A Co-Worker's Perspective

Assume for a moment that you and I work together. I was hired last week, and unfortunately, we have not had a chance to meet. Today you are out sick or on vacation. There is an emergency with one of your cases. I am on call and must see your client. Since you are not here, I will ask for the record. Is it legible? Current? Will your entries provide sufficient usable information to assure appropriate service and continuity? If you have not maintained meaningful documentation, I will probably ask the same questions you asked earlier, and the person will wonder why he or she must repeat information.

When entries are vague observations or unfounded judgments, I am uncertain as to the clinical significance. One note says, "Judy is unable to interact appropriately with others." Another entry says, "She watched TV today and seemed upset." Why was she upset, what did you do, and how did she respond? Our receptionist tells me that Judy is crying and agitated, but the record has little information

with which to work. I am told you saw this family seven times, but there are only four notes.

The assessment and plan contain *conclusionary terms*, that is, modifiers without explanation. I am unsure what you meant when you wrote,"She is overly active, too aggressive, and intentionally destructive. She also has a short attention span and is low functioning." I cannot imagine what could happen to relationships with clients who read their records only to learn they are viewed as immature, disorganized, combative, defiant, belligerent, unmotivated, inadequate, or explosive. Nevertheless, these words appear in the chart without clarification.

Several entries contain abbreviations that cause confusion. Does *ARC* mean American Red Cross? Alcohol Rehabilitation Center? Association for Retarded Citizens? Admission and Release Committee? Or AIDS-Related Complex? I need to know.

The more I read, the more uneasy I become, and Judy knows it. Before the session ends, I make an inappropriate referral, and I inadvertently break a confidence. Judy and her family are not satisfied with my intervention, and someone from the family decides to consult with a lawyer on the grounds of an incompetent counselor. Two days later, our organization is served with a malpractice lawsuit. Whose fault is that? It is the fault of a primary counselor who keeps inadequate records. You were the only one who had firsthand knowledge about this client, the client's problems, what had been done, and what needed to be done. Counselors must understand that others rely on their documentation when they are not available. Both primary counselor and co-worker are concerned about every client's welfare, and they must work together.

⚖

By now, you may be feeling some frustration and believe you cannot write an entry that will satisfy everyone. The fact is that you will not be able to write the perfect entry that will satisfy everyone. However, with some effort, you can establish and maintain a record that is understandable and accountable (legally, clinically, and fiscally).

Sometimes, it seems as though the whole world is on your back. That thought inspired a song that is appropriate at this point:

We've Got the Whole World on Our Back*

I serve people every day until I can't think straight.
I'm always outnumbered; that's my fate.
And, don't you know it—I'm law-suit bait!
The whole world's on our back!

This job of mine sure is fun.
At the end of a day I'm never done.
The real problem is my brain's gone numb.
The whole world's on our back!

Those friendly auditors are coming next week.
If they find me, I'm up a creek.
I think I'll play hide and seek.
The whole world's on our back!

I know that you are feeling blue.
Your antidepressant is just about due.
But I wish it was for me instead of you.
The whole world's on our back!

*Copyright 1992 by Robert Mitchell

Essential Elements in the Initial Assessment

The fact that you exercise what you consider to be good judgment may not protect you. Most counselors are qualified for the professional parts of their job, but few have training in the area of keeping records. However, when it comes to quality care and malpractice prevention, documentation is the key. You are only as good as your written word, so for the record, here are more ideas to build on.

Initial information-gathering tools serve as the foundation for subsequent interventions. The forms are a means of communication among professionals and help to insure continuity and appropriateness. They not only identify an individual but also provide, for example, demographic characteristics, referral sources, reasons for seeking help, and social and financial information.

You may want to develop more comprehensive assessment forms if you offer services to specific areas of the population, such as children or persons with a chemical dependency problem.

In most instances the counselor should obtain information from the client rather than from another source. When data are collected from another source, a counselor should make every effort to secure the client's written consent to obtain personal information from a third party. Every client has a right to know and understand the purpose of the collection of data as well as how the information will be used to make treatment decisions about him or her. Such client involvement permits an individual to make informed decisions about releasing information. Surprisingly, many individuals are unaware of why they are being interviewed in such depth.

The record should document the client's statement of needs. When appropriate and available, family members, legal guardians, and advocates should participate in identifying what they consider to be the needs and priorities. Another person's involvement will be determined by the client's level of functioning, age, or a court order, for example. Alternatively, the individual may be unwilling to receive services. Regardless, the person's willingness or unwillingness should be documented. Ideally, client and/or family involvement from the start promotes empowerment and leads to a more meaningful commitment to the treatment process.

Although a client's signature on a counselor's forms does not certify total understanding or agreement, it does confirm involvement. The signature is not always required by licensure organizations or funding sources, but I think it is a good idea. Why not get it?

Some states' laws require that clients be provided with fee schedules, copies of the counselor's or organization's philosophy of care, and an explanation of each party's rights and responsibilities before the initial assessment phase has been completed. The provision of these documents provides the basis for a client's informed participation in the assessment and subsequent counseling.

As you write, always remember the record is a reflection of you as a professional who can think and write clearly. It is small wonder that the public has misgivings about a counselor's ability to help. Consider this excerpt I found in a record review: "He's going through a stage. He has a mental deficiency. We could never get the family involved and of course you couldn't talk to him to send him off somewhere he could see somebody and try to figure out what

this is. . . . For a while he was really snowed with medications. . . . It's really academic what it is because there's nothing we can do. . . he's gotten to where he's just not eating . . . talking like they're trying to kill him. . . ."

Here is another example of writing that could cause confusion for the reader: "It was noticed that the patient was using PRN Ativan ordered excessively requiring a discontinuation of that medicine, but he was not overtly manipulative on the unit and appeared to comply with the milieu of regulations without any problems." Among others, the terms *excessively, manipulative*, and *milieu* are all pretty fuzzy.

Some notations, however, contain unintentional levity. Consider this entry. "Many years ago this woman was married and had a son who is 37 years old." An assessment form listed this problem statement: "Rob complains of being dressed [sic]." We may chuckle when we read this, but it does not do anything to make the record clear.

Client, Mr. Johnson would be upset (see the chapter Documentation: A Client's Perspective) and angry about the use of the word *deny* in his record. Sometimes, however, *deny* is the appropriate term to use. If, for example, a client is sitting in your office and exhibits such characteristics as a strong smell of whiskey, unfocused eyes, slurred words, a record that confirms six admissions to a detoxification unit, and a statement that says, "I've never had a problem with alcohol," it is appropriate to say he or she denies alcoholism because there is information to support such a statement.

The Assessment/Intake/History Form

An assessment, intake, or history form can be modified to meet your needs. It should include, but not be limited to, the following elements.

- **Date**: Month/day/year.
- **Re-entry?** If yes, list previous mental health, chemical dependency, and developmental disability treatment as well as name of treating facility, date of treatment, and reason.

- **Referral source:** Full name, address, and phone.
- **Client name:** An entry such as "Hank Williams" is of limited value if the client's name is Robert Henry Williams, and some of his friends and family also call him Bob. Avoid nicknames.
- **Social Security number:** Optional.
- **Sex.**
- **Race.**
- **Birth date:** Month/day/year.
- **Address:** Street name and number, city, state, zip code.
- **Phone number:** Include area code.
- **Education:** Highest grade completed, when and where; if still in school, indicate where.
- **Marital status:** Multiple marriages?
- **Children?** If yes, list names and ages.
- **Veteran?** If yes, list years of service, location, and type of responsibility.
- **Presenting problem(s) or chief complaint as listed by the client:** A statement such as, "Client and her husband had a slight argument the other night after he admitted drinking a little bit," is of limited value. Instead, specify the frequency or intensity of their arguments, the nature or frequency of such discussions, the extent of his drinking, and the precipitating factors.
- **Presenting problem(s) or chief complaint as listed by the referring source (when appropriate):** Instead of writing "episodes of excessive drinking with belligerent behavior," write, "Wife says that last week her husband, after drinking a six-pack, broke in the front door, tore the phone out of the wall, and hit her in the face while she was trying to protect the children."
- **Strengths and limitations as listed by client:** Instead of writing "steady employment," write, "He has been a truck driver with the Mercer Factory for 13 years."

- **Background information/precipitating factors:** A statement such as, "They were getting along well until last week," is of limited value because we do not know what *getting along well* means. The same can be said of statements such as, "There is a history of domestic violence when he has had a fair amount to drink." It's more helpful to write, "He says he has had one or more violent bloody fights every year for the past 3 years. Two years ago he was arrested after stabbing another man. He also admits to drinking and hitting or pushing his wife, on average, once a month for past 6 months."
- **Mental status:** Appearance, behavior, affect, orientation, cognitive functioning, memory, judgment, insight, perception of self. An entry with clinically useful information could be written like this: "The husband was 15 minutes late for his appointment and offered no explanation. He was unshaven, and his clothes appeared to have been worn for the last week as evidenced by the strong odor of perspiration. He answered questions with one or two words, would not elaborate when encouraged, and sat with his arms crossed in a defiant manner. It was not possible to determine level of intelligence, level of functioning, insights. He gave no evidence of a willingness to participate in counseling; in fact, he said he saw no value to it. The only reason he came was to satisfy his wife."
- **Risk assessment:** Suicidal or homicidal thoughts, access to weapon, self-mutilating behavior, history of angry outbursts (physical and/or verbal), degree of danger to self or other. Instead of writing, "He hit his wife numerous times when pretty drunk," write, "A 5-year history of domestic violence is evidenced by his wife's admission to the emergency room last year with a broken nose and multiple facial cuts, three emergency protective orders in the past 4 years, two house calls by the police after his wife phoned 911. The potential for violence is high especially since she told him she wants a divorce."
- **Physical condition:** Present or previous treatment? When? With whom? Reason? List any significant health issue that can impact treatment.

- **Other information as deemed appropriate by counselor:** Financial, educational, legal, spiritual, residential. The following is an example of an entry containing other clinically appropriate information: "Bart began drinking and experimenting with drugs in 1999. He did not want to discuss specifics because he says it has nothing to do with his current marital difficulty. Bart's father passed away in the detoxification center during his third admission. The father, reportedly, was physically and emotionally abusive to all members of the family."
- **Clinical impression and/or diagnosis.**
- **Disposition:** Be specific; write something like, "She requested and received authorization to live at the spouse abuse center for 2 weeks. She states there will be no additional reconciliations unless her husband seeks counseling and is cooperative with therapist."
- **Employed?** If yes, list employer name, address, phone number, job title, and responsibilities.
- **Income:** Specify amount and weekly, biweekly, or monthly.
- **Name, address, and phone of person or organization responsible for payment of service:** Insurance company, Medicaid, Medicare. List all active insurers and obtain copy of the current identification card. This also includes the dependent child/relative who may be eligible for insurance benefits.
- **Names and relationships of others living with client.**
- **Name of person who can be contacted in event of emergency:** (Include relationship to client and contact information.)
- **Name of father:** List full name and indicate if living or deceased; optional.
- **Name of mother:** List full name and indicate if living or deceased; optional.
- **Signature:** Name and credentials of counselor who completed the assessment form.

Entry-Writing Principles

No matter what stage of the counseling process you are in, there are certain basic operating principles to which you should adhere. Here are some of the more important ones:

As you write, all entries should be clearly labeled *factual* or *opinion*. Identify unverified information as such and list the source of information. Avoid verbatim repetition of information contained in correspondence received from other organizations. Use short sentences. Write to express facts, not impress someone with long technical entries. Pretentious language should be avoided. Confine each paragraph to a single topic.

Choice of language should be clear and specific also. Avoid negative terms such as *dysfunctional family, sexual psychopath*, or *heavy drinker*. Describe the behavior. Avoid irrelevant statements. For example, if the client is a child, there is no value to an entry that says "no military experience." Eliminate words when possible. Instead of writing, "The client does not have any brothers or sisters," write "No siblings." Use quotations to provide a better picture of the individual's thoughts and feelings. But don't forget to keep the quote short. Ask yourself this question, "Am I comfortable sharing with the client what I have written? Or reading it in the newspaper?"

Long words make the reader work harder, and they are more likely to be misunderstood. Use simple English and eliminate what writing teachers call *deadwood*. That is, for example, use

near	not *adjacent to*;
now	not *at this point in time*;
early	not *ahead of schedule*;
many	not *a large proportion of*;
full	not *filled to capacity*;
if	not *in the event*;
wore	not *attired in*;
after	not *immediately following*;
because	not *in view of the fact*;
except	not *with the exception of*;
suddenly	not *all of the sudden*; and
considered	not *took into consideration*.

Abstract phrases cause confusion and doubt. Write "April 11, 2001" not "soon," "someday," "in the near future," or "within a few days." Someone sent me a memo that said, "Staff assigned the vehicular spaces in the area adjacent next to our building are hereby informed that such utilization will be temporarily suspended on Monday of this week only." It should have said, "No parking allowed on Monday."

Look for ways to eliminate words; just one word per sentence can save you time and clarify an entry. If you write, "The client is now involved in her third month of intensive counseling," you could say, "Now in third month of counseling." Instead of, "The client denied any and all knowledge about the theft," you could write, "He said, 'I did not know about the robbery.' " Instead of writing, "The client, for the first time, acknowledged an awareness of child neglect," write, "He acknowledged awareness of child neglect."

The assessment should be written within 24 to 48 hours of the interview(s).

When an individual is seen for assessment but decides not to become involved in treatment, the session and outcome should be documented by the practitioner. In such cases, documentation and witness signatures can be very important. If the person leaves the site and does harm to self or another, the agency is in a vulnerable position. Should a lawsuit result, the lack of documentation could equate to *abandonment*. (For more information about abandonment, see the chapters Terminations and Discharges, and High-Risk Cases.)

Doing Your Part

Forms that are completed in a timely and accurate manner can assist in providing quality care as well as protect the legal interests of the service professional. Forms should be designed in such a way that a client is not asked to repeat information. Do your part to help stamp out and eradicate superfluous redundancy.

Documentation: A Client's Perspective

Previous chapters considered the perspectives of the attorney, the auditor, and the co-worker. This chapter focuses on the perspective of the central and most vulnerable figure in the counseling process: the client.

The first time a client is seen, it is not uncommon to say something like, "Mr. Johnson, I know this is a difficult time for you, but you are going to have to learn to trust and deal with feelings that you have been avoiding." As counseling progresses, the clients do trust. In fact, they may tell you things they have never told another human being. However, dissatisfied clients, former clients, or other affected third parties may see an attorney who convinces them to sue you. Their lawyer has a judge issue some orders, and the next thing you know they get not all, but a significant portion of what they consider to be "their" records. After all, it is their lives that a counselor is writing about.

If you wrote, "Mr. Johnson is evasive, impulsive, and appears to be manipulative and demanding," or described him as "unmotivated,

unresponsive, and showing poor judgment," did you discuss these issues with him? Did you let him know what was being placed in the record? Did you define the terms?

If a client says he or she had three brief hospitalizations in 12 years, write that. It is inaccurate and unfair to enter a sentence such as, "Client has a history of hospitalizations."

No one likes being told what to do, and a counselor's entry can, perhaps, indicate a double standard. For example, when a client speaks his or her mind, the record may describe the individual as "aggressive, resistive, or noncompliant." But from the client's point of view, when you or I express feelings, we're being "honest and open." When clients want to be left alone, they have been described as "isolating themselves," but when you or I don't want to be around others, we are "taking care of ourselves" or "relaxing." When we talk to a stranger, we are considered friendly, but counseling records may indicate this behavior in the client is "inappropriate."

It is not uncommon for a counselor to ask a client if she or he ever experienced hallucinations. When the client's answer is "No," do not write, "Mr. Johnson denies hallucinations." *Deny* is an interesting word and it has several meanings. How is a reader supposed to know what you mean? One definition is that the individual refuses to accept, admit, or acknowledge truth and reality. The counselor does not have a right to imply the existence of hallucinations, unless other entries in the record can confirm the problem. Sometimes *deny* is the appropriate word to use in describing a client, but be careful where and how you use this term.

Counselors often write about the client's family members. I recall reading about a wife who was supposed to take her husband (the client) to a vocational rehabilitation office for psychological testing, but she didn't get him there. The entry said, "Mrs. Johnson, like her husband, refuses to follow through." In reality, she did not refuse. The dictionary says *refuse* means to "willingly withhold compliance." On the day of that scheduled appointment, the client's favorite niece died in an automobile accident, so he and his wife spent the day with the child's mother trying to console her.

If clients kept records about their service providers, I have often wondered what they would write about us.

Analysis of a Summary Note

A summary note gives the counselor an opportunity to write one note that details multiple interventions. Depending upon the state in which you practice, it may be possible to write a daily summary, a weekly summary, or a monthly summary. It is the counselor's responsibility to know and comply with state regulations. However frequently it may be written, the summary note must contain substantive information that can be used to assure legal, clinical, and fiscal accountability.

Sample Summary Note

A frequent problem is that summary notes, like notes in general, often ramble, contain conflicting information, and are written unprofessionally. Here is a sample.

Weekly Summary for Feb 3. Appropriate mood, positive attitude, cooperative, and immature behavior, good concentration, stammering speech, average social intelligence, and fair judgment. Charles has participated in the program very well this week. He said he had spent some time at home and now he wants to look for an apartment again. Said that he and the man at his home had an argument. It was nothing serious but he thinks he would be happier on his own. Charles said that he needed winter gloves and needed a voucher to go to Community Clothing Store and pick them up. I talked to the man at Community Clothing Store on Feb 5 who has told me that Charles called him to say that he has a voucher but could not get down to pick up gloves and asked the man if he could deliver them to him. I talked with Charles about this matter and he just smiled and said that he did not know that they would not deliver. This is an example of Charles's judgment. Continue on 1:1 for support. Continue in work program.

(Signature/credentials)

Analysis

- *Weekly Summary for Feb 3:* What year? Records are taken apart now and then. How could you possibly verify the year of service? What days of the week was client seen? How many hours per day?
- *Appropriate mood, positive attitude, cooperative.* These are conclusionary words that can mean many things to many readers; be specific. (For more information about conclusionary terms, see the chapters Documentation: An Auditor's Perspective; Documentation: A Client's Perspective; and Case Management Considerations.)
- *and immature behavior.* These words contradict previous information and are vague. What is immature to you may not be considered immature by someone else. And what is immature in one culture may not be immature in another. We deal with more ethnically diverse clients each year, so be sensitive.

- *good concentration, stammering speech, average social intelligence, and fair judgment.* More vague judgmental statements, unless these terms have been defined in the assessment.

- *Charles has participated in the program very well this week.* Look for ways to eliminate unnecessary words. If you saved yourself 20 words a day, that is 100 words a week, and 5,200 words a year! The word *has* is not needed. What is the evidence of participation? What is the meaning of *very well*? As a matter of fact, you can eliminate the word *very* from your vocabulary. A truly good writer also is especially careful to practically eliminate the too frequent use of adverbs and adjectives.

- *He said he had spent some time at home and now he wants to look for an apartment again.* How much time? What home? Is there previous material that explains why he wants to look for a home? Where does the client live?

- *Said that he and the man at his home had an argument. It was nothing serious but he thinks he would be happier on his own.* Who is the man? What was the nature of the argument and what clinical significance does it have? Is this a behavior pattern? How serious is *serious*?

- *Charles said that he needed winter gloves and needed a voucher to go to Community Clothing Store and pick them up.* This thought appears from nowhere! Records need logic. We were reading about an argument and a desire for a new home.

- *I talked to the man at Community Clothing Store on Feb 5 who has told me that Charles called him to say that he has a voucher but could not get down to pick up gloves and asked the man if he could deliver them to him.* Who is the man at Community Clothing Store? Has he been involved in other matters pertaining to Charles? Clumsy wording.

- *I talked with Charles about this matter and he just smiled and said that he did not know that they would not deliver. This is an example of Charles's judgment.* How is this an example of judgment?

- *Continue on 1:1 for support. Continue in work program.* There is no evidence that Charles has been involved in a vocational program.

Suggested Rewrite

The rewrite that follows here isn't perfect, but it certainly is an example of how to provide more useful and professional information.

Weekly Summary for Vocational Program February 3, 2002.

Monday	Tuesday	Wednesday	Thursday	Friday
2/3	2/4	2/5	2/6	2/7
4 hours	4 hours	6 hours	0 hours	2 hours

Services provided:

Prevocational adjustment

Medication monitoring

Vocational support

Group therapy

Individual therapy

Psychosocial rehabilitation

Charles did not attend program on Thursday and was 2 hours late on Friday. He said he was "upset" because of an argument with an uncle who is temporarily living in the home. He said he did not want to discuss it but added, "It wasn't serious. I just wish I had my own place." I encouraged his goal of independent living while reminding him of the need to have a job/income.

Advised Charles that arrangements had been made for him to pick up winter clothing from Ms. Moore, Community Clothing Store, on Saturday, 02/08/2002.

Program focus: Need to be on time everyday; need to follow instructions without two or three prompts; need to take medications as prescribed (he admitted not taking medications on Tuesday and Wednesday); need to discuss problems rather than "disappear" as has been his pattern for past 8 months.

Plan: Continue vocational program 5 days a week and individual therapy as indicated.

Because we spend so much time on paperwork, here is a song with humor and recognition for the difficult job of a counselor.

Tons of Paperwork*

You write 16 tons and what do you get?
Another day older and stiff in the neck!
Saint Peter don't you call me to the bright shore.
I still have to do a whole lot more.

I got to the office in the nick of time.
Three emergencies standing in line.
Sally and Jim had called in sick and
when the day ended I was ready for a trip
to the nearest mental hospital.

Eighty-nine cases that need a plan.
At the end of a day, I can hardly stand.
But I'll tell you one thing that's tried and true,
I feel real good about the job I do!

If you see me coming you'd better step aside.
I'm trained and ready, filed with pride.
I'll do my job day after day,
believe it or not, in spite of the pay!

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High-Risk Cases

Risk is an ever present reality in the counseling arena. Immunity from legal liability has almost disappeared. The possibility of legal or fiscal losses that can result from inadequate documentation offers a compelling reason to ensure that records are precise and current. Counselors tend to be optimistic and do not anticipate being involved in costly, possibly ugly, legal disputes. But as the bumper sticker says, "Stuff happens!" Records are vital to reconstruct the course of treatment. Your best defense for survival is to anticipate and be prepared.

Malpractice suits are changing the traditional definition of confidentiality, and suits that question treatment or diagnosis are becoming more common each year. Documentation, or lack of it, can make the difference in a favorable or unfavorable decision. Laws differ from state to state, and they change from day to day. Laws are not absolutely clear on every possible area of exposure. In fact, many issues have yet to be ruled on.

There has always been and always will be a delicate balance between a client's right and the public good. It is not an absolute issue, yet we constantly strive to find that elusive balance. I met President John F. Kennedy, and in one of his speeches he said something to the effect, "Go forth and do the things that you know need to be done. A good conscience will be your only sure reward." My advice is do your best; write with pride and accuracy. Some issues are not resolvable to everyone's satisfaction, and documentation is one such issue. You will not be able to create a chart that will satisfy every human being. Nevertheless, I hope this chapter provides useful ideas for you to build on when documenting high-risk cases.

Qualifiers, Violence, and Threats of Violence

If you write, "This client may be potentially dangerous," you must do three things: explain how you reached the conclusion, act, and document the action. Action options would include, but not be limited to, (a) notifying a potential target and/or the appropriate law enforcement agency, (b) consulting with a psychiatrist, (c) completing a case review, and (d) considering an involuntary hospitalization. Inaction must be explained. For example, if you choose not to warn an intended target, document the reason(s). Someone can always question your action or inaction, but at least you have established a defense.

When you believe someone may be homicidal or suicidal, put it in the record, but always explain how you reached the conclusion. This is easily done by using the client's own words or describing the behaviors.

When a client threatens to injure or kill someone, you may have a duty to warn the potential target. A counselor's obligation to maintain confidentiality will not apply when disclosure is necessary to prevent harm to the client or to specifically named individual(s), or when state and federal laws require disclosure without client consent, for example, in child abuse cases. In such instances, you should seek consultation with your co-workers, supervisor, and a lawyer, and document those consultations in your record. Remarks about homicide and suicide must always be taken seriously and always documented.

The client may say he or she has no intention to harm self or another, but if your professional intuition or the content of the chart gives you cause for concern, this may be just the appropriate place to use a word like *appears* or *possibly* because no one can be sure of everything. Ask the client how he or she feels and use the client's words.

It is not possible to eliminate the use of all qualifiers, but eliminate them as often as possible. When records are filled with a preponderance of qualifiers, you may appear so incompetent you should be sued or lose funding. There is no rule that says it is okay to use *appears* three times a month, *seems* twice a month, and *possibly* one time a month. But these words create doubt, so as I have indicated earlier, use them sparingly.

I recall reading an assessment that contained 20 qualifiers. In one workshop example, there is a staff note with five qualifiers. It says, among other things, the client seems satisfied, seems she wrote a letter, seems relaxed, seems to smile easily, and is possibly suicidal.

Let's discuss each one of those qualifications. When satisfaction and relaxation have clinical significance, do not qualify them. Say to the client, "You seem more satisfied than when you came in 6 months ago. How are you feeling?" If the person says, "I had not thought of it, but yes, I do feel more satisfied," then write it! Not only do you document progress but you also eliminate the doubt. Good writing is said to be 80 to 90% listening. Write it like you hear it. But if you put quotation marks on a page, the words must be exact, not approximations. How can you be sure it is exact? Keep it short, one phrase, and, at the most, one sentence. I have read records containing paragraph after paragraph in quotes. That is not reasonable unless you can verify the session was recorded and this note is the official transcription.

Seems she wrote a letter? Seems to smile easily? If a letter and a smile have clinical significance, they should not be qualified. When there is no clinical relevance, who cares? Auditors, lawyers, and support staff who maintain records have told me when they read an assessment, plan, and subsequent notes, they cannot tell they are reading about the same person. Too often, notes ramble about a series of events or problems that have no relationship to

previous entries. The next time you prepare to write an entry, ask yourself, "Does this sentence have anything to do with the problems or goals listed in the most recent plan or the initial assessment?" If your answer is yes, write it. If your answer is no, why do you complain about paper work and why do you write it?

There is a caution, however, because clients' lives can and do change from one contact to the next. I recall working with a person who was preparing to return to the job market after a series of psychiatric hospitalizations. Therefore, all problems and goals were related to specific vocational issues. But one day he came to my office upset and crying. He said something like this, "I do not want to live any longer. Every time I make an investment of myself in someone or something, they leave me or they die! I can't take the pain and rejection anymore! I'd be better off dead." Based on what I said about relating the note to the plan, do you think I could have said, "You have not been on time once this week, you are not taking the medication as it was prescribed, and your breaks have been too long"? No. And I do not believe you could, either. After a series of questions, I learned his dog had died the previous night. I also discovered the dog had died on the same night his mother had died the previous year. I helped him recognize that his emotional hurt was natural, due in part to the anniversary syndrome. I assisted with unfinished grief work. That was the service and that is what I wrote. What does that have to do with vocational skills? Nothing! So use your best judgment. If, however, my client becomes obsessed with loss and dying, I need a case review that lists the new problem and goal.

What about that phrase "possibly suicidal"? Does it fit a person who "seems satisfied, relaxed, and smiles easily?" Yet the possibility of suicidal behavior is the single most important issue requiring a counselor's clarification. If you are not there tomorrow and I have to see this person, I need to know what the person was feeling and what you did. Ask! On the one hand, if the person says, "I am so depressed I'm killing myself tonight," we know. And we eliminate qualifiers like *possible*.

On the other hand, the client might say, "Don't worry about me. I know I overreact. I will not hurt myself or anyone else." If your

professional intuition or other information in the chart causes concern and you are not sure, it is probably best to use words like *may be suicidal* or *possibly suicidal*. But do not forget that when you write the word *suicidal* or *homicidal*, you must also let a reader know how you reached this conclusion and you must act.

Once you make an entry regarding the possibility of a high-risk behavior, you impose legal obligations on yourself, and you must act by, for example, alerting a potential target or considering an involuntary commitment. Whatever action you take, document it. If the last note in your record indicates the person might harm self or other but does not include what action you have taken, and the client follows through, your defense is very limited because you are a professional and a professional should know better than to let a "possibly suicidal person" walk away. The legal case against a counselor is called *abandonment*. (For more information, see the chapter Terminations and Discharges.)

Someone sent me a news article: "A federal aviation spokesperson said the crash could have been caused by the wings falling off the plane." I rest my case about the use of qualifiers.

Physical and Sexual Abuse

When you have reason to suspect abuse, neglect, or criminal behavior, discuss the case with a lawyer and contact the appropriate law enforcement agency if the law requires a report. Good documentation is critical, and entries should be made on the same date as the event. Content should clearly confirm the action taken and the outcome (if any).

When physical, emotional, or sexual abuse is suspected, extreme caution must be taken. The best approach is to document the client's words and behaviors rather than express an unfounded opinion or suspicion.

I recall attending a workshop in which an attorney read a letter from a young girl who said she had been raped by her mother's boyfriend. The note pleaded, "Please don't tell anyone. He says he will kill me and my mother. Get the police. I need help." Such documentation clearly provides a reader with the client's concern.

When a child is in therapy, the child's attorney and the child's therapist must work hand in hand for the child's interest. The counselor should attempt to have records sealed or reviewed only by the judge to determine if anything is relevant.

As noted in the first edition of this monograph, there must be constant awareness of risk management and loss prevention principles. To do less increases vulnerability. The plaintiff's attorney is duty bound to be the client's best possible advocate. Your feelings, opinions, and documents are of use only insofar as they contribute to a financial settlement of the client's claim.

The opposition's goal is to establish credibility, even if it requires the destruction of your reputation. The validity of your records will be challenged, and information will be reviewed with a fine-toothed comb.

It will be important for you to be able to show that you acted in good faith, within the scope of your job function, and in compliance with your internal standards of care. Do not provide ammunition to the plaintiff's attorney. Without adequate documentation, credibility and professionalism can easily be questioned.

Before you write a court report, obtain a clear understanding of what is needed and why. Your responsibility to the client is to provide only the requested information. Do not write letters based on what you think someone may want because you might inadvertently violate a client's right to privacy. Do not respond unless the client signed a release or you have a court order. Be sure to retain that release or order in your records.

Intent to harm may or may not have an effect on a jury decision. There are several variables to consider. If, for example, someone is practicing casting with a new fishing rod and does not see you come up behind him or her, and the hook lands in your arm, you would probably be awarded damages based on his or her negligence, but you would probably not be awarded punitive damages because it was not done with intent to harm. If, for another example, you and the other person had a fight and you walked into his or her backyard and he or she said with anger, "How does this feel?" and cast the hook directly at you, you could probably obtain a larger settlement. Likewise, if you put information in a letter or a record that may be

considered harmful from the client's point of view, then your liability risk is increased. So if you are writing about a client you do not like or may be angry with, be sure your words pertain only to the client's situation and do not reflect your negative attitude(s).

If your letter appears to be speculation rather than statements of fact or a clearly defined professional opinion, it does disservice to you, your agency, your client, and the court. My experience indicates that judges and lawyers prefer clear writing. They like strong verbs, short sentences, use of first person, and positive forms. They do not like abstract nouns, long sentences, hard-to-understand phrases, third person, and negative forms.

Criminal Behavior

When a client admits having committed a crime or an intent to commit a crime, you have ethical and legal decisions to make. Clients must be advised that confidentiality has its limits and that the law requires a counselor to report child abuse, elder abuse, and threats against another's life, for example. (See *Tarasoff v. Board of Regents*, 1976.)

Even though a client may be psychotic, destruction of property, harassment, and violence or threats of violence are criminal behaviors. You have an obligation to protect yourself, other staff, other clients, and the general public. Depending upon the degree of seriousness of these actions or threats of actions, calling the police for assistance may be appropriate and necessary. After an arrest or other court disposition, counseling may still be needed and offered. In such cases, documentation is of utmost importance. However, this monograph cannot assist you in making a determination about continuing to serve the client. A counselor makes this decision based only on his or her professional judgment and the specifics of the individual case.

Permission for Service Form

Whether the case is high risk or not, one basic form is important: the permission for service or the consent for treatment. The contents of this form are often specified by state licensure law. This

document is the client's or the client's legal representative's authorization for you to provide service or treatment. The signature is of utmost importance, and several considerations must be involved. Is the client's level of functioning sufficient for him or her to know what is being signed? Will the chart verify it? Is the client legally competent to sign? If not, do you have a copy of the court order?

Extreme caution must be taken if the client is a minor. Do you have a legal guardian's signature or a copy of the court order? In some states a minor can sign for limited services: be sure you know what is acceptable in your state. Generally, a minor may consent to and receive limited treatment if the professional's best judgment is that the risk to life or health is of such a nature that treatment must be given without delay. Again, good documentation is essential.

Treatment should be given only after a client has signed a permission form. The length and complexity of forms, however, can be detriments. For example, an attorney may attempt to show that the client could not understand what was being signed because forms were too confusing or the implications of those forms were not fully explained.

The permission for service form for an adult should contain at least the following elements:

- a statement such as "Permission for service is hereby authorized for (counselor or organization) to render service/treatment to (name) whose relationship to me is (circle one) self; child; spouse; other (be specific)";
- a statement such as "I understand that (counselor or organization) may terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, threats of violence, involvement in criminal behavior." (Note: This item could be deleted from a consent form if the issue is explained in a rights and responsibilities statement that is given to every client. Refer to the chapter Terminations and Discharges.);
- signature of client or signature of client's legal representative if needed;
- signature of a witness if needed;

- date; and
- a statement such as "A copy of this consent form was given to the client. (Circle one) Yes No".

The permission for service form for a minor should contain essentially the same kind of information as mentioned for an adult as well as specific reference to the legal status of the client, that is,

- married minor;
- married minor with child;
- emancipated minor (not financially supported by family and not under control of parents, or any other guardian);
- minor in need of treatment for drug abuse or addiction or under the influence; or
- minor in need of immediate treatment and requiring parental or guardian consent (chart must contain specific data).

Additional Considerations

1. In many states, the signature of a minor is not legally binding. Counselors must be aware of their state's statutes.
2. Do not ask clients to sign blank forms to be dated and used later.
3. Not all documentation is admissible in a court of law. So before you agree to take a counseling record to court, find out what is and what is not admissible in your state.
4. In an emergency or high-risk case, discuss your concerns with an attorney, document the consultation, and then act in accordance with the legal advice. Counselors may wish to keep their notes of consultation with the attorney in a separate chart. Then the consultation notes will be privileged until disclosed in accordance with prevailing law.
5. Stick to the facts and avoid statements that are impressionistic or defamatory. Avoid conclusionary words or undefined modi-

fiers such as *homicidal, suicidal, delusional, dangerous, unfit, abusive,* and *violent*. Rather than use an adjective, translate the necessary information into a verb that clarifies an observable behavior.

6. Exercise caution when listing other individuals' names in a chart. For example, if someone is having an extramarital affair, do not record the lover's name. However, it is appropriate to list names if you have consulted, for example, with an attorney, another counselor, a school teacher.

7. Suicide and homicide contracts can be clinically useful because they verify the counselor's attempt to help the client understand the seriousness of a situation. Nevertheless, in litigation, a contract does not always protect you.

8. *Delayed disclosure* is a complex and controversial issue. In a court of law, the plaintiff's attorney will challenge the validity of recovered memories and attempt to convince a jury that a counselor caused a client to generate false memories of events. Therefore, it is important to remember that documentation is not only a treatment tool but also a potential legal document that may be used against you. How good is your record keeping? What will it show about your approach, intervention, and technique?

   Don't forget that lives other than the client's can be affected. For example, a family member or someone in the community (such as a teacher or a neighbor) could initiate a lawsuit against the counselor who is treating a client who claims to have been sexually abused by that person in childhood. This is dangerous territory, so the counselor must exercise caution. Clients could be experiencing flashbacks associated with post-traumatic stress syndrome. Document what you did and how you did it. Maintain neutrality and objectivity. Be careful about suggestions. It is also important to remember that only a counselor with training, certification, and experience should implement techniques such as hypnosis and guided imagery.

9. Be as open and honest as you can be in working with clients and/or families. Involve your client as often as possible in the

documentation process. It can enhance the service relationship, promote empowerment, and make paperwork easier. To know that something is written down, and not have any idea what that something is, can produce anxiety or inhibition. Clients can co-sign entries and be offered the opportunity to write their own notes. It is another method of helping a client develop self-awareness.

Some malpractice suits contend a provider gave bad advice or did not tell the client what to expect. Often, discontent lies behind a law suit, and one possible way to keep someone satisfied is to involve him or her in the documentation process. Clients may be less likely to subpoena a record if they know the contents are *their* words.

Involving the person can also increase a client's understanding before a session is ended. Many times an interview is terminated on the assumption that the patient heard and understood everything. Sometimes they are overwhelmed with multiple stressors and do not hear or understand. Obviously, involving the client will not work with everyone, but it is an idea you can use more often than you might believe.

Need for Specificity

Achieving effective communication is a complicated task in every aspect of our society. Other publications about documentation or other trainers may declare specificity is the worst possible thing to include in the record, but I say specificity is absolutely essential.

Vague words can cause problems in every segment of society. Several years ago, there was so much confusion about terms such as *reduced fat* and *low fat* that the federal government had to set national standards, so people could know what they bought. As this monograph was being prepared, I read a newspaper article with the following headline: "It's the puzzle of trying to eat right: What's a 'portion'?" According to the reporter, the U.S. government, individual states, and most food manufacturers do not use the same standards or vocabulary. No one could agree about what constitutes a

serving. For instance, a muffin was considered a serving, but there is no reference to size or weight, so there was limited value to the term *serving*.

Given that documentation in counseling records must be precise and comprehensive, what happens when counselors aren't careful? You may find, as I have, entries like these in client charts:

- "Patty's mother remains deceased at this present time."
- "When eating a sandwich, Sharon will take one bite at a time for 5 days."
- "Rita is some better than the last week. Wednesday she took a little nap on the cat."
- "Larry, age 5, wrote his name on the blackboard exactly backwards. He shows signs of major improvement."
- "Mickey made progress in bed wetting but not as much as he could have."
- A prescription: "Zantac 300 mg. Take one tablet daily after supper to prevent acid rain at night."
- "Carolyn was apparently born when her mother was only 14."

Seriously, without current and accurate documentation, risk exposure is increased. But please remember, we are talking about minimizing risk, not eliminating it. Decisions must be made on a case-by-case basis, and no book or workshop will provide you with a failsafe system of record keeping. When in doubt, consult with an attorney.

Substance Abuse and Chemical Dependency Considerations

The contents of a drug or alcohol chart should contain, at a minimum, the following: intake form, consents to treat and/or copy of court order, signed statement of client rights, treatment plan, case review, staff notes, lab results, medical history, physician's orders (if any), correspondence (sent and received), termination summary, and an aftercare plan.

In the event of a lawsuit, an attorney will look for a documented, logical connection between a client's needs, goals listed in a plan of care, and the service activities. In the event of an audit, fiscal examiners look for the same things.

To illustrate, consider for one moment that you are another service provider, a lawyer, or the funding source. Then react to the

following full text notes from files of patients diagnosed with substance abuse and/or chemical dependency problems:

1. Attendance perfect this week. She continues to sit by herself and doesn't get involved.
2. He participates in work training with high productivity marks.
3. Attended chalk talk. Was unusually cooperative; comments were appropriate and reasonable.
4. Shows very relaxed behavior and appears to be making serious changes in regard to treatment. Group was urged to continue progress and given next month's meeting date.
5. Seems to be doing well. Is following up with tasks and finding a nice balance in his life. Most of session was spent just chitchatting with client looking at no real problems. At this point in time, just looking for support.

Such entries as these five examples are of limited, if any, value. You must explain what you mean and what you do. A simple statement does not a staff note make. Ask yourself how many ways each word could be defined; then define words that can have multiple meanings. Too often, entries are only observations or unfounded opinions. What would happen to your relationship with clients if they read words such as *negative attitude, belligerent, poor employment risk, unmotivated, minimal insight, unwilling, defiant*, or *persistent behavior problem*? Suggested revisions for each of the five preceding full-text-note entries are as follows:

1. Janice attended five group therapy sessions this week. Unlike last week, she was on time for each session, so this is progress. She continues to sit by herself, maintain silence, and does not respond to questions or comments. Group members were supportive and assured Janice they understood the pain of a divorce. She cried and, for first time, began to deal with a terminated relationship.
2. Jessie participated in the work training program 3 of 5 days. His motivation is evident by on-time arrival, task completion with-

out supervision, and compliance with medication. On Wednesday he enrolled himself in a local GED class.

3. Karen attended third chalk talk. She asked questions and made comments related to the 12-step program. The first two sessions she disagreed or challenged everyone, but tonight her involvement was positive. The group mentioned her behavior change and said they liked her better. Karen acknowledged her previous confrontational behavior and said she had always had to fight to express an opinion and was not accustomed to a free exchange of expression. She believes the group sessions are a learning experience.
4. David is usually anxious as evidenced by loud laughter, nervous back-and-forth leg movements, and blinking eyes. Today, however, none of the anxious behavior was evident. He verbalized a recognition of his pattern of blaming others for his drinking.
5. *The last example as listed above does not verify a professional counseling session and has no place in the record.*

When you write a plan of care, words should permit the client or another service provider to know what the problems and goals are. For example, "Will be cooperative" is not a clear objective. To make it clear, determine what pattern of behavior or verbal statement will allow the client, you, or someone else to know when the goal of cooperation has been reached. The goal can make sense if the client says "I will keep appointments," or "I will remain seated during group," or "I will listen to others without interrupting."

Another unclear problem statement is the single word *alcoholism*. To make it clear, write "arrested on 12/22/2001 for DUI, lost job due to excessive absenteeism. Admits to drinking a six-pack or more each day." A third unclear example of a problem statement is "Strengthen coping skills." What does that mean? Why not write "Recognize own anger and replace drinking pattern with workouts in gym and calls to AA sponsor"?

Examples are endless. Instead of writing "Become responsible," write "Accept responsibility for own behavior rather than blaming others," or "report to group on time," or "attend all scheduled activities without prompts." And instead of "Use leisure time constructively," write "Attend GED classes" or "Become a volunteer for cystic fibrosis."

A plan is always designed to fit the individual needs of the client, but at the same time, you must be aware of state and federal mandates. A state may require client participation for a specific number of days prior to discharge. Should this not be included in the plan, or should the client be discharged prior to the dates required, your risk exposure has increased. Another state may require a specific number of hours of drug education as an adjunct to treatment. When a chart does not verify compliance with such protocol, legal liability has again increased. Do you know what is required in your state? Do you know how many days a client may be kept in treatment on an involuntary basis? If you placed a woman on the inpatient unit and kept her 2 extra days, and if she was raped after she should have been discharged, what might be the consequence? (For more information about the contents of a plan, see the chapter Documentation: An Auditor's Perspective.)

If an individual has been ordered by the court to participate in the program but has failed to keep appointments, and the chart does not verify an attempt to get the client in, or if you have failed to alert the court about noncompliance and a criminal act is committed, your legal position is weakened.

A comprehensive admission or intake form is of utmost importance. Drug and/or alcohol history and evidence of current dependence on drugs and/or alcohol must be documented. Evidence can be obtained by noting signs of withdrawal during the initial period of abstinence or by noting the presence of needle marks. In some instances, relatives and friends can also provide additional history. In the case of drug dependency, the content should allow another reader to know what drugs are involved: heroin, methadone, alcohol, barbiturates, amphetamines, cocaine, marijuana, hallucinogens, inhalants. The content should not permit another reader to

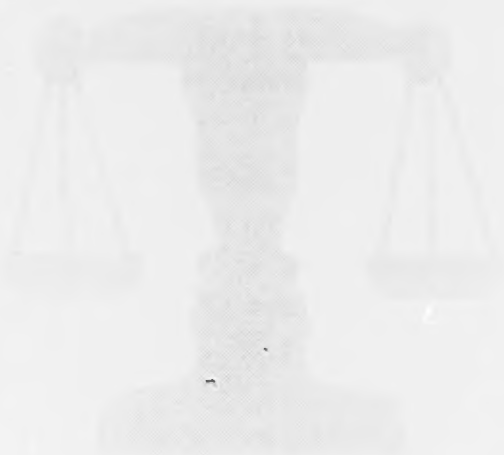
guess about the extent of drug use. Be specific: daily, two times a day, weekly, three times a week, monthly.

Depending upon what state you live in, staff notes may be one of two types: per-contact notes that are written within 2 days of the provided service or weekly summary notes. Obviously, if you are required to do contact notes, but the chart is filled with weekly notes, your legal and fiscal risk exposure is increased.

When drug surveillance is part of treatment, a urinalysis should be performed randomly, and the results must be documented in the record. If methadone is part of the treatment program, the record must clearly document the dates and dosage amounts and all changes in dosage.

In some instances, the service provider must be a Certified Chemical Dependency Counselor (CCDC). A record could be your only defense in a lawsuit or a financial audit. Will your record verify compliance with state regulations?

Considering the high percentage of cases involving substance and chemical dependency, attention to documentation detail is particularly crucial.



Terminations and Discharges

When the work is done, and the case is closed, there is another dimension to counseling that is often forgotten or neglected. The final official piece of documentation in the counseling record is a termination or discharge summary. Your closing statement, like all other sections of the record, must be well written to confirm professional interventions.

The two most obvious reasons for good documentation in the termination summary are (1) a client returns for additional service and/or (2) a client or the client's legal representative initiates a malpractice suit. An increasingly cited basis of a malpractice suit against the counselor is abandonment.

With these thoughts in mind, read the following letter and termination summary. Make a list of your concerns about content and/or lack of content. Then rewrite the letter and termination summary. The analyses, suggested rewrites, and discussion of abandonment that follow will provide some guidance.

The Letter

Original letter, September 23, 2001.

Dear Mrs. King:

It has been quite some time since I have seen or heard from you. I would be interested in knowing how you are and if I can be of any further help to you.

Please contact me at 123-4567 by October 14, 2001. If I have not heard from you by then, I will assume that you wish to terminate services.

I look forward to hearing from you in the near future.

[signature/credentials]

Analysis.

- *It has been quite some time since I have seen or heard from you.* When was the last service? How long is "quite some time"? What was the nature of the last contact?
- *I would be interested in knowing how you are and if I can be of any further help to you.* This sentence implies the counselor has been a help to the client. Is there a basis for this belief? Does the counselor actually want to serve the client again, or is this a meaningless statement that is included in all letters?
- *Please contact me at 123-4567 by October 14, 2001. If I have not heard from you by then, I will assume that you wish to terminate services. I look forward to hearing from you in the near future.* The letter implies the counselor is looking forward to the client's return. Again, is this remark a common courtesy? What if the counselor did not want the client to return? Why does the counselor "assume" the client does not want service? Why not state a closure date if no contact?

Suggested rewrite.

Dear Mrs. King:

You have not phoned or kept an appointment since February 16, 2001. This letter is to assure you of our continu-

ing interest in your welfare. Please let me know within the next 3 weeks if you want to return for additional counseling.

My notes reminded me of our discussion about your belief that therapy is not necessary. The choice is yours, but many people have found that regularly scheduled sessions coupled with medication have been helpful to those suffering from depression. I suggest you return to therapy either here or with another community agency of your choice. You may call the regional hot-line at 123-4242 when you need emergency or referral services. Your files will be closed if you have not contacted us by October 14. Please understand, however, that you may return at any future date.

[signature/credentials]

The Termination Summary

Original termination summary for Mrs. King, October 31, 2001.

- **Reason for closure:** Client not seen since February 16, 2001.
- **Summary of progress toward goals including final diagnostic impression:** Clt appeared to make little progress—continues c ^ psychiatric symptoms when uses etoh—denies etoh is problem. Acute depression. Paranoid delusional d/o. Etoh dep.
- **Follow-up plan:** No response to follow-up letter.
- **Other pertinent information:** [This eight-line section of the form was left blank.]

Analysis.

- *Reason for closure: Client not seen since February 16, 2001.* Was there any outreach between February (date of last appointment) and October (date of this summary)? If yes, were the letters, home visits, and/or phone calls documented? If no, will the chart verify this acutely depressed client was never a danger to herself or others?
- *Summary of progress toward goals including final diagnostic impression: Clt appeared to make little progress.* Is the word

appeared necessary? Can the phrase *little progress* be defined? What area improved? What problems remained unchanged? How many times was she seen?

- *Continues c ^ psychiatric symptoms when uses etoh—denies etoh is problem. Acute depression. Paranoid.* What symptoms were exhibited? What services were offered? How did the client respond to counseling? Are you sure *denies* is the correct word? Perhaps she is incapable. Remember how Mr. Johnson, the former client, felt in the chapter Documentation: A Client's Perspective? Are the abbreviations understandable? (For more information about abbreviations, see the chapters Documentation: A Co-Worker's Perspective and Frequently Asked Questions.)
- *Follow-up plan: No response to follow-up letter.* This is a statement of fact, but it is not a plan.
- *Other pertinent information:* This eight-line section of the form was left blank. Blank spaces create doubt about your ability to obtain clinical information or the genuineness of your interest in the client.

Suggested rewrite.

- **Reason for termination:** Client was seen eight times between November 4, 2000, and February 16, 2001. She did not agree with the judge's referral and stated she did not want counseling because she considers it a waste of time. She did not respond to three messages left on her answering machine or two letters urging her to return to counseling.
- **Summary of progress:** Client seen five times by counselor, two times by psychologist, and once by the psychiatrist. She was delusional and paranoid as evidenced by repeated statements such as, "People are trying to kill me. I can't trust anyone." She would not consider a voluntary hospitalization, and her family was unwilling to consider a mental inquest warrant. No progress.
- **Final diagnostic impression:** 296.3 Major Depressive Disorder Recurrent; 295.30 Schizophrenia (subtype) Paranoid Type; 291.5 Alcohol-Induced Psychotic Disorder, With Delusions.

- **Follow-up plan:** Write letter to assure client of interest and encourage the use of counseling/medication.
- **Other pertinent information:** 42 years old, divorced, two adult children living out of state. Saw Dr. Ralph Stanley, private psychiatrist, and was hospitalized for acute depression in December 1999. Client reported being sexually abused as a child.

Abandonment

If the client just discussed should commit suicide, attempt suicide, or harm or kill another person, abandonment could be a concern. *Abandonment* is the negligent interruption or termination of services. Risk exposure increases when

1. a client comes to treatment erratically;
2. records do not verify outreach efforts to a client who breaks/misses appointments;
3. high-risk clients drop out of treatment;
4. a client is "fired" or refused service;
5. a professional therapist and client have not discussed/agreed on closure;
6. a client is not notified in writing that the case is being "closed";
7. the record indicates a failure to review/consult/refer; or
8. staff notes do not verify that a plan is being followed.

To reduce the opportunity of being charged with abandonment, here are a few suggestions:

- When you terminate a case, provide the client with a written, factual basis for the closure and keep a copy in the record.
- Be courteous, sincere, and professional. Provide the client with names and phone numbers of other therapists and/or community resources.

- Outline the closure plan with an emphasis on the client's responsibilities after termination.
- Document efforts to contact a client when appointments are not kept.
- Discuss outstanding fees briefly and do not threaten legal action.
- When a client cannot be located, consider notification through a friend or family member. When an agency concludes that a friend or family member should not be notified or when the agency is unable to locate the client, the decision "not to notify" or "unable to notify" should be documented.

The ACA *Code of Ethics and Standards of Practice* (1995) stated

> Counselors do not abandon or neglect clients. . . . Counselors assist in making appropriate arrangements for the continuation of treatment, when necessary, during interruptions such as vacations, and following termination (A. 11.a). If counselors determine an inability to be of professional assistance to clients, they avoid entering or immediately terminate a counseling relationship. . . . (A. 11.b.)

Right to Refuse Treatment

Sometimes a client will not comply with the plan of care, is violent or threatens violence, or for a variety of reasons is uncooperative. Even though the counselor's intention is to help the individual achieve the highest level of functioning and participate as fully as possible in a satisfying life, such a goal contains elements that are beyond a counselor's control. There may be occasions when services may be discontinued by the counseling professional. In these cases, refusal to provide service must be carefully and accurately documented, preferably with consultation and signed approval by a supervisor, primary physician, or psychiatrist. Conversations between the counselor and his or her legal representative should be documented, although attorneys do not usually provide signed consultations. Hopefully, a client and/or his or her legal representative will participate in the process before closure.

Documentation in the record must verify one or more of the following issues: refusal to take medication as prescribed, a pattern of failure to follow treatment recommendations, violent behavior or threats of violent behavior, repeated canceled or unkept appointments, and criminal behavior.

Regardless of the rationale for an involuntary cessation of treatment, a case review should be conducted. If you are in private practice, the review could include other professionals from the community or your own professional organization(s). The review must be documented and include the names and credentials of each participant. A copy of the review could be made available to the client.

When a client or legal guardian cannot or will not participate in the termination process, it is important for the professional to reach out actively to encourage participation, through phone calls and letters for example. Always document your efforts, and if letters are returned, file them in the chart with the original postmarked envelope.

The issues of termination and right to refuse service should be discussed with a client at the time of an initial assessment, unless determined clinically inappropriate. These issues can also be addressed when the permission for service form is signed, or it can be explained in a rights and responsibilities statement/policy that is provided to every client. (See the chapters Essential Elements in the Initial Assessment and High-Risk Cases.)

The ACA *Code of Ethics and Standards of Practice* (1995) stated

> Counselors terminate a relationship, securing client agreement when possible, when it is reasonably clear that the client is no longer benefiting, when services are no longer required, when counseling no longer serves the client's needs or interests, when clients do not pay fees charged, or when the agency or institution limits do not allow provision of further services. (A. 11.c)

⚖

Doing good isn't easy. We are in a tough business, and it's getting tougher each day. If you're not feeling stressed out, I don't know why. In fact, I detect a condition I refer to as post-training traumatic syndrome, so before we proceed, here's one of my songs to treat that condition.

I Need a Respite*

Databases and diagnosis,
case reviews and prognosis.
I think I have a new psychosis.
I am buried in a pile of paperwork.
I need a respite.

Every few years, it's a brand new game.
That DSM won't stay the same.
If it's ever finished, I'll be insane.
I am buried in a pile of paperwork.
I need a respite.

Most staff meetings are a waste of time.
They don't have much reason or rhyme.
Bored and angry, that's what I'm.
I am buried in a pile of paperwork.
I need a respite.

*Copyright 1992 by Robert Mitchell

Case Management Considerations

Case managers, by virtue of their education, are generally not certified or licensed counselors, clinicians, or therapists. Nevertheless, certified counselors, clinicians, and therapists (in a community mental health center, for example) frequently find themselves working with the same clients. Case managers must always work closely with counselors to help clients secure needed services and monitor progress.

The ACA *Code of Ethics and Standards of Practice* (1995) stated, "If a client is receiving services from another mental health professional, counselors, with client consent, inform the professional persons already involved and develop clear agreements to avoid confusion and conflict for the client" (A.4.).

When case managers do not have counselor certification or licensure and extend their activity beyond case management as described in this chapter, they may increase their risk exposure

because in a lawsuit the attorney will surely attempt to convince a jury that the service provider was not qualified.

As noted in previous chapters, a record must be an accurate reflection of the service interventions and professional judgments. Noncompliance with funding source regulations could also result in a lawsuit if a payer contends that services were not necessary or that documentation was missing or embellished.

Essential elements of case management are as follows:

1. **Assessment and reassessment** with the patient, physicians, nurses, guardians, parents, primary therapist, or any other significant person who may be knowledgeable about the patient's needs: In the following fictional example, note the logical sequence of services that follow assessment. But note also that the case manager does not offer any type of mental health counseling or therapy. "Met with Larry to assess mental status. Mr. Armstrong, neighbor, reports patient is pulling drapery off the window and hearing voices. In our session, patient talked coherently but attention wandered as he picked at clothing and furniture. Called to set appointment with Dr. Green, Psychiatric Clinic, Friday at 4:00 p.m. Patient informed. Also called Dr. Mary Kaelin to request evaluation of patient's medications. She will see Larry tomorrow at 3:00 p.m."

2. **Arranging** for the patient to receive, for example, an appointment with a dentist, physician, or food stamp eligibility worker, or transportation to grocery: The following example indicates arranging. "Arranged for patient to be seen on January 21 at 9:00 a.m. by county health department for TB screening. Also called Behavioral Health Center to arrange for transportation."

3. **Informing** the patient of community resources and keeping the patient abreast of everything you are doing on her or his behalf and/or what the patient needs to do to meet goals identified in the plan: Consider the following fictional notes: (a) "Informed patient of pending psychological evaluation and uses of evaluation for possible SSI benefits," and (b) "At request of the family, met with patient to inform her of the death of an uncle.

Discussed with Kay Gunderson, apartment manager, who will provide transportation to funeral. Informed patient."

4. **Assisting** the patient in matters such as housing, health care, clothing, part-time or full-time work, transportation, social activities, Social Security benefits, clothing, dental care, social or recreational activities, medication: The following fictional examples indicate assisting. (a) "Assisted in communicating her needs/concerns to her attorney and Division Social Service case worker regarding termination of parental rights," and (b) "Spoke with Dave Riffe, Division Social Service. Assisted with completion of an application for energy assistance."

5. **Monitoring** quality of patient service and compliance with the plan of care: For example, "Monitored client at the Ima Rose Bush Home Cooking Cafeteria. I will advise vocational counselor that the client was on time, finished each task, complied with the break schedule, and was polite to customers."

Case management usually includes but is not limited to the following components:

1. **Residential:** Assistance with admission procedures. Assessment of need for, for example, shelter, furniture, cookware. Monitor how residential placement meets the patient needs.

2. **Psychiatric:** Referrals to inpatient and outpatient clinics as needed. Arrange for therapy on a schedule consistent with patient's plan of care. Monitor client follow-up with physician-prescribed medication orders.

3. **Physical health:** Includes but is not limited to vision, dental, personal hygiene, nutrition. A goal might include something like this: "Have weight checked every 2 months. Arrange to have blood pressure checked every 8 weeks."

4. **Day placement:** Meeting with residential staff to facilitate admission. Inform patient of program rules, schedules, details, potential challenges and problems. A goal might read like this: "Re-assess with patient, every month, suitability of program for

her or his needs. Meet with staff every month to determine progress and satisfaction."

5. **Education:** Assessment of need or interest in additional educational classes or videotaped materials from a community college (such as coping with depression, substance abuse, psychiatric medications).
6. **Vocational:** Assessment of what patient wants and is able to do in the area of employment or volunteer activity. Referral to vocational rehabilitation counselor when indicated.
7. **Financial:** Assessment of financial status; SSI, food stamps, Medicaid; spending money, fuel assistance, food, clothing. Assist client to establish a savings account.
8. **Communication:** Assessment of ability to communicate, verbally or in writing. Arrange for training related to using phone, writing letters, or expressing self.
9. **Social:** Assessment of need or interest in recreational activities. Arrange for activity in accordance with client's interest and social goals.

Working within the parameters just discussed, the case manager is an important part of the total counseling team.

Frequently Asked Questions

Q. All I want to do is serve people in need. Paperwork has nothing to do with the quality of my service or the outcome. Why is documentation so important?

A. Other professionals will need the record for multiple uses. These include, for example, use by

- the primary provider in order to adhere to established plan of care and assure continuity;
- another staff person in order to assure appropriate intervention when the primary provider is not available;
- the primary provider's supervisor in order to review quality of service and adherence to plan of care, and evaluate provider's professional growth;

- the utilization review and quality assurance committee in order to evaluate appropriateness of service, review use of professional time, and examine program effectiveness;
- the state auditor and any other external monitor in order to determine compliance with licensure and/or funding source regulations; and
- the plaintiff's attorney in order to educate the jury by pointing out missing dates, changed dates, wrong dates, missing notes/plans, vague entries, inconsistent or conflicting information.

Q. If my documentation is subpoenaed, what options do I have?

A. The best direction will be obtained from a lawyer. Nevertheless, here are several suggestions:

- You should verify the validity of a subpoena or court order.
- You should make sure you have appropriate client consent or have called the client's attorney to see if he or she will file a motion to quash the subpoena.
- You may be able to submit a duplicate client record that has been certified as correct, or you may be required to appear in court to testify. Less staff time is used when a certified record is provided, but there is no opportunity for the counselor to offer clarification.
- If you are permitted and choose to submit a certified copy, it is important to hand deliver the material only to the individual specified on the subpoena and obtain a receipt or use certified mail with return receipt service. The certification form should contain, at least, the name and signature of the record custodian; the name, signature, and seal of a notary public; the name and ID number of subpoenaed record; the total number of pages being copied; the name, address, and phone number of the organization that provided services; and a statement such as, "I certify that the attached copies are a true and complete reproduction of the original documentation. This certification is provided in lieu of a personal appearance."

- If you are required to appear in person, do not permit examination of the documentation and do not give up possession of counseling records until instructed to do so by the judge.
- Do not create documentation especially for the purpose of a particular proceeding.

Q. What can be done about entries that were never written and/or entries that were written but cannot be found?

A. Several factors must be considered. Is the case active or closed? Is the counselor an employee or a former employee? How long has the information been missing or lost?

Missing items in documentation: If the counselor is still an employee, entries should be made within 24 hours of the discovery or at the counselor's earliest opportunity. Documentation must list actual service date(s) and date of the belated entry. If a long period of time has elapsed since the entry should have been made, all the counselor can do is indicate that the belated entry represents his or her best memory of what occurred.

If the counselor is no longer an employee, every effort should be made to contact the provider in an effort to have him or her write entries within a reasonable time of the discovery. If the counselor cannot be located or fails to submit the missing data, another professional can make an entry to explain the situation. Documentation must list actual service date(s), date of the belated entry, and an explanation. If the client is active, he or she should be informed of the situation, sign another permission to treat form, and perhaps be allowed to read/cosign late entries. If these entries have been subpoenaed, and there is no way to contact the former employee, the court should be notified that documentation is not available but that another professional can testify from existing entries that are filed in the chart, or from memory if there is personal knowledge of the client's situation.

Missing records (entire chart): If the counselor is still an employee, a new chart should be established within 24 hours of the discovery. The new file should be labeled *Replacement Record*. Documentation must explain that the original folder was lost and

specify the date range that is being addressed from memory. Also list the date of the belated entries. If the lost record has been subpoenaed, the court should be notified that documentation is not available but that the professional can testify from memory.

If the counselor is no longer an employee, every effort should be made to contact the provider to have him or her write entries within a reasonable time of the discovery. If the counselor cannot be located or fails to submit the missing data, another professional can make an entry to explain the situation. The new file should be labeled *Replacement Record*. Documentation must explain that the original folder was lost and specify the specific date range that is being addressed from memory. Also list the date the belated entries were made. If the client is active, he or she should be informed of the situation, sign another permission to treat form, and perhaps be allowed to read/cosign late entries. If these entries have been subpoenaed, the court should be notified that documentation is not available but that another professional who knew the case can testify from memory.

A court order can require you to produce a record before the court, even if a client will not give permission to release information. For a more comprehensive understanding of this topic, see Volume I in the ACA Legal Series, *Preparing for Court Appearances* by Theodore P. Remley, Jr., JD, PhD.

Q. Is it wise to keep two records, that is, the primary record for everyday use and an unofficial chart that contains personal notations and client statements or information that others would use for negative reasons?

A. Although some state laws may immunize personal notes from discovery, in my opinion, it is not wise to keep two sets of records. To do so is actually creating more paperwork. I recall one workshop participant telling me about a separate set of records that were written in a foreign language to prevent others from accessing client information. That is not absolute protection because other people can read foreign languages. In addition, anything that is discoverable, depending upon the nature of the case, might be ordered into court. If you are successful in keeping the existence of such records

a secret but are called into court, you may be asked if you have provided all pertinent records. To lie about the existence of other information is perjury.

In a related matter, I recall another person telling me about staff who were instructed to write so illegibly that no one could read clinical entries. The thinking was the records could not be used against staff. I suggest you maintain one legible, current, understandable, and comprehensive record.

Q. Please comment on filing systems and security.

A. Records should be used on the day of service delivery and returned to a storage area at day's end. It is also important to document when a chart is removed from the records department. This can be accomplished through the use of a sign-out slip. The person who signed out the chart becomes responsible for its security.

Every effort should be made to insure that charts are not taken out of the building. If records are used outside the office, there must be a specific policy, and there must be compliance with that policy.

Care should also be taken to insure that records are not left in view in unattended offices. When you are going to be out of the office, and there is even a remote possibility that someone could enter the office and see client information, the chart should be locked in a desk.

Some charts, usually substance abuse charts, must be filed and secured in accordance with federal regulations. Certain other records, such as employee assistance program charts, records of an employee's family member, or records of a locally prominent person, may also need special procedures. All charts should be maintained under the supervision of an office manager. If you are in private practice, then you also may be the office manager!

Q. How do I handle correspondence and drawings?

A. Preferably, correspondence, copies of prescriptions, lab reports, drawings, and other loose materials should be filed on a daily basis to prevent loss or possible breach of client confidentiality. Such materials should be filed at least on a weekly basis.

Drawings, for example, should contain an explanation of clinical implications rather than simply be placed in a folder. When a drawing indicates a seriously depressed individual who might do harm to self or others, there must also be an accompanying clinical entry that documents what intervention followed.

Accurate filing can help prevent breach of confidentiality and insure continuity of care. During the preparation of this book, my primary physician needed X rays that had been taken in the preceding 15 months. One hospital gave me a folder containing not only my records but also another patient's records. A second medical facility was unable to locate any X rays, and my doctor had to repeat the tests.

Q. What about cosignatures? Are they really important?

A. A cosignature serves as confirmation of training or supervision. Students completing a field placement should have all entries cosigned, and the cosigner must accept the legal, ethical, and clinical implications of his or her signature. This is not an issue to be taken lightly.

Some states and some funding sources will accept only the signature of a "recognized," "covered," or "qualified" professional. Each state is different, so it is your responsibility to find out what is required. Professionals with some bachelor's and some master's degrees may not be acceptable as primary care providers or as supervisors. Usually, a professional with a state license or certification is acceptable.

If supervision was not provided, the note should not be cosigned simply to obtain reimbursement. To do so is unethical and illegal.

Each time anyone in the organization provides a service or has direct contact with a client or the client's legal representative, there is a risk. The risk is more complicated when that someone is a student or volunteer. Not only can these individuals be hurt on the job, but they can also render a service that results in a lawsuit.

In addition, there are financial considerations because students and volunteers, in most instances, may not bill for their services. Further, it is important to understand labor laws that could restrict

their activities. The Department of Labor may recognize some individuals as exempt from Fair Labor Standards, but it is your responsibility to know and to comply.

If students and volunteers provide counseling, will their level of education and previous experience (if any) verify the person is qualified to be working with clients, especially if the client has a history of hospitalizations or any behavior pattern that might be construed as high risk? Volunteers and students can be positive components of quality programming; however, the best strategy is to prevent an incident that leads to a lawsuit or a repayment.

Q. Why is it important to list patient time or professional time in a clinical entry?

A. It is important to remember that we live and work within a legal system designed to protect the rights of every individual. Unhappy clients who sue you may say they were seen for only 15 minutes, when in fact, you provided a 2-hour crisis stabilization session. Written words have more reliability than a counselor's memory.

Additionally, record keeping must verify legally reimbursable activity. Often, billing is based on patient time, that is, direct time, usually face to face, with a client. Professional time is a combination of staff time used in the delivery of service plus time used to make interpretations of tests, write-up time, and perhaps travel time. The entries you make are essential to assure reimbursement for service rendered.

Q. What relationship do brochures and flyers have to documentation in the record?

A. Printed materials are promises to your clients and your community. Therefore, they must be accurate descriptions of staff qualifications, services offered, and anything else you want someone to know. Do not make promises that cannot be kept. Additionally, the printed materials flyer will tell you what needs to be in the counseling record.

If the flyer, for example, states that each client will have an individualized plan of care developed by a multidisciplinary treatment

team consisting of counselor, psychologist, nurse, social worker, case manager, and psychiatrist, then it is necessary to have such a plan in every record. I frequently read records that do not list any staff name other than the person who wrote the plan. Some may contain the cosignature of a supervisor or a psychiatrist, but there is no evidence they actually participated in the development of the plan or case review.

If the brochure indicates that staff have special qualifications or lists credentials, licenses, and certifications, then charts must be signed by staff who have earned such credentials.

When advertising materials indicate the availability of emergency or after-hour services, they must be available. And when these services are provided, the clinical entry should be labeled as such.

If a brochure indicates there will be an opportunity for the client to assess and strengthen vocational skills (or whatever), a record must verify the client's participation throughout the counseling process.

When the material provides information about success rates, your office should have a separate and current file with information that confirms such claims, that is, reduce alcohol/drug related offenses, obtain and keep a job, successful short-term therapy for marital discord, or fewer hospitalizations.

If the literature states a client will be seen within a specific number of hours or days, an overview of your records must be able to confirm it happens. How would it look if the record showed a high-risk client called for an appointment on April 9, overdosed in a suicide attempt on April 13, but was not scheduled to be seen until April 30?

Q. Documentation no longer fits neatly in one folder. What guidelines are there for subsequent volumes?

A. When an individual has been in treatment for a long time, the size of a record can make the documentation difficult to use. The obvious solution is to create another volume.

On the front side of the original record, place the following information:

- "Volume I";
- date of the first and last entry; and
- "See Volume II for additional information."

On the front side of the next record, place the following information:

- "Volume II";
- date of the first entry; and
- "See Volume I for additional information."

Q. Does every staff note, treatment plan, case review, and letter have to be original? I could save time if forms and letters were preprinted.

A. Clinical forms can be partially preprinted, but every form must contain some handwritten information that has not been preprinted, that is, observation(s), opinion(s), and client response(s). The signature should also be original.

Form letters could be prepared for a variety of purposes, including, but not limited to, appointment confirmation or cancellation, missed appointments, response to a request for information, attempts to contact a client, and thank-you notes to a referral source. The signature, however, should be original.

Q. My clients use slang and vulgar language. Should I use their words in the record?

A. The record is a professional document, primarily maintained to insure appropriate treatment. As such, it must contain information that you or another must rely on to optimize quality care and risk management prevention. To obtain an accurate perception of the client, it is important to provide an accurate picture of the person being served, but it is not necessary to fill a record with slang and vulgarities. Perhaps you could quote the individual on one occasion and then cross-reference the reader to a specific date for an example of "inappropriate or vulgar language."

Q. What legal security is offered by a disclaimer form?

A. Any form can be attacked and questioned by a plaintiff's attorney, but there is some value in a disclaimer form because it is confirmation that the counselor made an effort to advise a client of risk. No form will provide unlimited and total protection, but you are encouraged to have forms that specify risk and verify the client's informed consent.

The best kind of disclaimer is one that informs the client of possible risks in order to permit an informed decision. However, although the form can be important, it is more important to make sound clinical decisions relative to the risk involved. Is the event on or off agency property? Will you or another employee provide transportation in a personal automobile? Will clients drive themselves or others? Is the event necessary (listed in the treatment plan) or is it "encouraged"? How old is the client? Is he or she legally able to sign a consent/disclaimer form? Is the event inside or outside? What physical activity is involved? Obviously, for persons with disabilities, there are different risks for a hike in the woods and for sitting in a theater. Common sense and good clinical judgment are required. If a picnic is held 25 miles from the office and seven clients (two of whom have a history of violent and aggressive behavior) are in an auto designed for five passengers, and if a volunteer or student is driving, risk exposure has been increased and the value of a disclaimer form is diminished. All events must be evaluated for clinical appropriateness and safety. Is it possible to substitute another activity with less risk but equal treatment value? Will clients or guardians be given the opportunity to decline participation? Is all of this being documented?

Disclaimers can improve patient-client communication and encourage both parties to utilize precautionary measures. Therefore, liability shields can also be an effective management tool. However, the form must address specific concerns in a specific time frame. A sample liability disclaimer form should include the following text and information:

1. My participation at (name activity) is voluntary. I understand the event is not required but can assist me in the attainment of

treatment goals I agree with. No liability will be imposed upon (name of individual or organization) for any injury that I may sustain. Should emergency treatment be required, I authorize said service. I have read and understand the content and intent of this form and acknowledge consent by my signature.

2. Client signature and date
3. Parent or guardian signature and date, if needed
4. Witness signature and date.

Finally, liability shields will never provide protection from criminal behavior or professional negligence.

Q. Are abbreviations always acceptable?

A. No. Abbreviations can save time, but they do not always mean the same thing to everyone. The chapter Documentation: A Co-Worker's Perspective mentioned, for example, that *ARC* can mean American Red Cross, alcohol rehabilitation center, Association for Retarded Citizens, admission and release committee, or AIDS-related complex. Other examples are as follows:

- *SW* can mean social worker, software, single white, or sad and worried.
- *APA* can mean American Psychological Association or American Psychiatry Association.
- *Mo* can mean month or mother. If the letter o is deleted, it can mean male.
- *PT* can mean physical therapy or protein.
- *AMA* can mean against medical advice or American Medical Association.
- *BM* might indicate behavior modification in one setting and bowel movement in another.

In addition, as already noted, one letter can make a difference. F might indicate female, but add the letter a, and it means father. One

letter also changes the meaning of a word; that is why spelling is so important, as in lost and last. The list is endless. Here are some of the most universally acceptable abbreviations:

ASAP	for *as soon as possible*
DD	for *developmental disability*
DOB	for *date of birth*
d/c	for *discharge*
EAP	for *employee assistance program*
ER	for *emergency room*
Eval	for *evaluation*
ETOH	for *alcohol*
GED	for *graduate equivalent diploma*
Hx	for *history*
ICF	for *intermediate care facility*
IHP	for *individual habilitation plan*
LD	for *learning disability*
LOF	for *level of functioning*
MH	for *mental health*
MIW	for *mental inquest warrant*
N/A	for *not applicable*
N/V	for *nausea and vomiting*
OBS	for *organic brain syndrome*
OP	for *outpatient*
PCH	for *personal care home*
PRN	for *as needed*
Rx	for *prescription*
SNF	for *skilled nursing facility*
SSDI	for *Social Security disability income*
Tx	for *treatment*
w/o	for *without*
y/o	for *years old*

If you do not have an approved list of abbreviations, develop a lexicon for yourself. Then be sure everyone uses it. We must have a mutually understandable vocabulary!

Q. Should client information be faxed?

A. A patient's right to privacy is compromised each time information is faxed. Unless the situation is critical (life and death), the use of fax machines is discouraged. There is a major breach of confidentiality should the information be accidentally received by an unintended person. If you fax, the transmission must contain a cover letter to a specific individual stating that the information is confidential and intended for use only by that person, and that receipt must be acknowledged. The cover letter must let an unintended reader know that dissemination of said material is prohibited. Finally, the letter should contain the name, address, phone number, and fax number of the sender with a request for the unintended recipient to immediately notify the sender. The original cover letter and acknowledgment of receipt are filed in the counseling record.

Q. What guidelines are there for dealing with HIV clients?

A. Unfortunately, there is not much legal guidance in terms of what to document or not document. As noted in the first edition of this monograph, you should probably lean toward protecting the client's right to confidentiality. A lawyer once told me, "Whichever way you go, you are deciding which lawsuit you want to face."

Another attorney told me that serious problems could arise from failure to document information about AIDS. She said a diagnosis of HIV/AIDS is extremely traumatic and will certainly be relevant to the mental health of any client. Because the counseling record is the means by which you document care and understanding of the client, meaningful entries are critical to treatment decisions. Failure to document such a major concern in the client's life could lead to malpractice. In a sense, the omission of this important information provides some level of confidentiality for the client, but it is a poor way to protect yourself.

The fact that you do not write what you know does not eliminate the fact that you know something. Problems most often result from failure to document rather than from making an entry. In all likelihood, you will not protect yourself by not writing, especially if a client says something like, "I have AIDS and I don't care if I pass

it on. If fact, I hope I can pass it on to (the specific name of a person who shares sex and/or needles)."

A counselor's most pressing ethical predicament, of course, is having knowledge about AIDS and not knowing where the client's right to privacy ends and the right to know begins for any exposed individuals, inclusive of, but not limited to, the client's sexual partner(s) or someone who shares needles. Ultimately, the choice of what to do and what to document is yours alone. Every situation is unique and requires a review with a lawyer. It must also be understood that this monograph is not a substitute for legal advice. In no event is the American Counseling Association or the author liable for damages that may result from the use of any publication in the Legal Series.

The ACA *Code of Ethics and Standards of Practice* (1995) stated

> A counselor who receives information confirming that a client has a disease commonly known to be both communicable and fatal is justified in disclosing information to an identifiable third party, who by his or her relationship with the client is at a high risk of contracting the disease. Prior to making a disclosure the counselor should ascertain that the client has not already informed the third party about his or her disease and that the client is not intending to inform the third party in the immediate future. (B.1.d.)

Q. Our job is difficult and often misunderstood. Some people just want to use records against us. Why should we expose ourselves to risk day after day?

A. Because it is a worthy endeavor to care for another human being and help others achieve self sufficiency and happiness. For further thoughts on this answer, see the Epilogue.

EPILOGUE: YOU MAKE A DIFFERENCE

Until we meet again or for the first time, be kind to yourself and remember you are an important person. You may not always believe it, but it's true. You make a difference everyday. A rock thrown in the water cannot know about the ripples it will make. You are more than a rock, and you too will make ripples that affect other lives.

In fact, people you have never met can have an impact on your life. Let me tell you a story. My wife and I went out for dinner. We were seated next to a table with a young man and his two children. The father was talking with his son about responsible behavior and was quite good, just the right amount of warmth and support. The child, however, was 5 years old and not interested in that kind of discussion. I was not sure the boy was paying attention to his father, when out of nowhere, the child looked into his father's eyes and said, "You know what the problem is? All I need is a bigger box of crayons."

About that time a waitress placed their dinners on the table, and they shared a meal they probably do not remember. However, it is a meal my wife and I will never forget. Years have gone by, yet even today, when either of us complains about something, the other one says, "All you need is a bigger box of crayons." We both laugh, and for a moment, things do not seem quite as bad. The father and his son will never know about the joy and hope they put into our lives. You too will affect other lives. Sometimes you will know about it, and sometimes you will not. The persons you influenced may not know it was something you said or did, but someday, somewhere, there will be a change in a thought process or a pattern of behavior. No one can say with certainty just when a change will occur or how long it will last. But I am convinced that the quality of another life

is going to be better because of you. The next time you doubt that you make a difference, remember this story. And, if necessary, get yourself a bigger box of crayons.

One of my favorite movies is the musical version of *Goodbye Mr. Chips*. As the movie ends, an aging teacher looks back over his life and wonders if he made a difference in the lives of his students. He sings a song that says, in part, "In the evening of my life I shall look to the sunset . . . And the question I shall ask, only I can answer. Was I brave and strong and true? Did I fill the world with love my whole life through?" Years from now, I believe the world will be a better place because you are here today filling it with love and professional help. I thank you for that and want to share the words of a song that I sometimes use to conclude my workshop:

The Good Fight*

If you're at the desk by the stroke of eight,
You know for sure that you're not late.
Tomorrow is an audit from the state.
So before you leave, don't forget to dictate.
I work everyday to motivate
But first there are strengths to evaluate
And feelings to translate.
Sometimes, I alleviate, formulate, educate, facilitate
or take a much needed break for some chocolate.
Then I return to elucidate,
negotiate, or tabulate
And when the day ends, it's very late.
Much of life seems disproportionate
As we try to habilitate those who deteriorate
So I'll give it to you straight.
Your challenge is the ultimate.
But you're fighting the good fight,
So hang in there and be proud!

*Copyright 1992 by Robert W. Mitchell

REFERENCES, SUGGESTED READINGS, AND WEB SITES

This monograph is based on 40 years of experience and countless numbers of books, articles, discussions, and workshops. It is impossible to credit each source of information in this book. However, the following may be useful.

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Web Sites

American Association of Homes and Services for the Aging: www.aahsa.org

American Association of Marriage and Family Therapy: www.aamft.org

American Counseling Association: www.counseling.org

American Health Lawyers Association: www.healthlawyers.org

American Nursing Association: www.nursingworld.org

American Psychiatric Association: www.psych.org

American Psychological Association: www.apa.org
Child Welfare League of America: www.cwla.org
Health Care Financing Administration (HCFA) (Medicaid and Medicare Regulations): www.hcfa.gov
International Association of Psycho-Social Rehabilitation: www.iasrs.org
Joint Commission on Accreditation of Healthcare Organizations: www.jcaho.org
National Association of Qualified Mental Retardation Professionals: www.qmrp.org
National Association of Social Workers: www.naswdc.org
National Council for Community Behavioral Healthcare: www.nccbh.org
Mitchell, Robert (author of this monograph): http://pages.prodigy.net/b_mitchell

NOTES

"Bob Mitchell, an expert noted for his clinical sensitivity and wise judgments, teaches the significance of documentation to both beginning and experienced practitioners in this wonderful, informative resource."

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"Mitchell deals with documentation in such a way that you learn and laugh and learn some more. You need to have this book on your desk. It contains very useful information presented without the 'legalese' that can drive you nuts."

—John C. Simmons, MSW, NHA
Mayfield Rehab and Special Care Center
Smyrna, TN

This empowering text details the importance of record keeping in today's litigious society. Mitchell offers practical guidelines on how to keep client records that are legally, clinically, and fiscally sound. By following the advice given in this timely book, professional counselors can help protect themselves from potential lawsuits, assist in court cases, speed third-party reimbursements, master electronic record keeping, and enhance the quality of care through efficient communication.

Robert W. Mitchell, ACSW, is the Internal compliance editor for Seven Counties Services, Inc., a mental health/developmental disability/substance abuse agency in Louisville, Kentucky. Mr. Mitchell has provided documentation training for more than 150,000 professionals in 41 states and Canada.

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